Filing Company: Kanawha Insurance Company State Tracking Number:

Company Tracking Number: AR-12-006 KIC WVB

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Applications (KIC) WVB

Project Name/Number: SB Life Enhancement/AR-12-006 KIC SBE

### Filing at a Glance

Company: Kanawha Insurance Company

Product Name: Applications (KIC) WVB SERFF Tr Num: HUMA-128309463 State: Arkansas TOI: H21 Health - Other SERFF Status: Closed-Approved-State Tr Num:

Closed

Sub-TOI: H21.000 Health - Other Co Tr Num: AR-12-006 KIC WVB State Status: Approved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Erin Hermsen, John Disposition Date: 05/01/2012

Goodwin, Lisa Geary, Tina Huettl, Christi Conrad

Date Submitted: 04/26/2012 Disposition Status: Approved-

Deemer Date:

Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

### **General Information**

Project Name: SB Life Enhancement Status of Filing in Domicile: Not Filed

Project Number: AR-12-006 KIC SBE

Requested Filing Mode: Review & Approval

Date Approved in Domicile:

Domicile Status Comments: na

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Small and Large

Group Market Type: Employer Overall Rate Impact:

Filing Status Changed: 05/01/2012 State Status Changed: 05/01/2012

State Status Changed. 05/01/2012

Created By: Erin Hermsen Submitted By: Erin Hermsen

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null Healthcare.gov ID: Filing Description:

This is a new filing; the attached forms do not replace or supersede any like forms previously filed. These forms are for use in the group market. These forms are being filed for general use with all approved policy series and may be offered in a printed, online, or digitized audio recorded format.

Filing Company: Kanawha Insurance Company State Tracking Number:

Company Tracking Number: AR-12-006 KIC WVB

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Applications (KIC) WVB

Project Name/Number: SB Life Enhancement/AR-12-006 KIC SBE

This application will be used to support our currently marketed products in your state. The changes in the application reflect cosmetic changes in format, design and language. These changes are intended to create a more consumer friendly application form for our future applicants to assist them in understanding the application process. Included with this submission are the following documents:

- ·Certificate of Readability; and
- ·Filing Fee of \$200 (\$50 per form).

To the best of our knowledge, we believe the attached forms satisfy the minimum requirements of applicable Arkansas statutes and regulations.

If you have any questions regarding this filing, please contact me via SERFF or by phone at (800) 558-4444 extension 5083.

State Narrative:

### **Company and Contact**

### **Filing Contact Information**

Erin Hermsen, Specialty Benefits Compliance ehermsen@humana.com

Consultant

325 Reid Street 920-337-5083 [Phone]
De Pere, WI 54115 920-632-0197 [FAX]

**Filing Company Information** 

Kanawha Insurance Company CoCode: 65110 State of Domicile: South Carolina

210 South White Street Group Code: 119 Company Type:
Lancaster, SC 29720 Group Name: State ID Number:

(800) 635-4252 ext. [Phone] FEIN Number: 57-0380426

-----

### Filing Fees

Fee Required? Yes
Fee Amount: \$200.00
Retaliatory? No

Fee Explanation: 4 forms @ \$50 each

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Filing Company: Kanawha Insurance Company State Tracking Number:

Company Tracking Number: AR-12-006 KIC WVB

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Applications (KIC) WVB

Project Name/Number: SB Life Enhancement/AR-12-006 KIC SBE

Kanawha Insurance Company \$200.00 04/26/2012 58650180

Filing Company: Kanawha Insurance Company State Tracking Number:

Company Tracking Number: AR-12-006 KIC WVB

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Applications (KIC) WVB

Project Name/Number: SB Life Enhancement/AR-12-006 KIC SBE

## **Correspondence Summary**

### **Dispositions**

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	05/01/2012	05/01/2012

Filing Company: Kanawha Insurance Company State Tracking Number:

Company Tracking Number: AR-12-006 KIC WVB

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Applications (KIC) WVB

Project Name/Number: SB Life Enhancement/AR-12-006 KIC SBE

### **Disposition**

Disposition Date: 05/01/2012

Implementation Date: Status: Approved-Closed HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Filing Company: Kanawha Insurance Company State Tracking Number:

Company Tracking Number: AR-12-006 KIC WVB

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Applications (KIC) WVB

Project Name/Number: SB Life Enhancement/AR-12-006 KIC SBE

Schedule	Schedule Item	Schedule Item Status	<b>Public Access</b>
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	100+ Employer Group Application	Approved-Closed	Yes
Form	2-99 Employer Group Application	Approved-Closed	Yes
Form	Group Employee and Individual App and	Approved-Closed	Yes
	Enrollment form 2-99 Employees		
Form	Large Group Employee and Individual	Approved-Closed	Yes
	App and Enrollment form		

Filing Company: Kanawha Insurance Company State Tracking Number:

Company Tracking Number: AR-12-006 KIC WVB

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Applications (KIC) WVB

Project Name/Number: SB Life Enhancement/AR-12-006 KIC SBE

### Form Schedule

### **Lead Form Number:**

Schedule	Form	Form Type	Form Name	Action	Action Specific	Readability	Attachment
Item	Number				Data		
Status							
Approved-	AR-71012-	Application	100+ Employer	Initial			AR-71012-
Closed	EA-LG	Enrollment	Group Application				EA-LG-
05/01/2012	4/2012	Form					20120417.pdf
Approved-	AR-71012-	Application	2-99 Employer Group	Initial			AR-71012-
Closed	EA-SB	Enrollment	Application				EA-SB-
05/01/2012	4/2012	Form					20120417.pdf
Approved-	AR-72000	Application	Group Employee and	Initial			AR-72000-
Closed	4/2012	Enrollment	Individual App and				20120417.pdf
05/01/2012		Form	Enrollment form 2-99				
			Employees				
Approved-	AR-72001	Application	Large Group	Initial			AR-72001-
Closed	4/2012	Enrollment	Employee and				20120417.pdf
05/01/2012		Form	Individual App and				
			Enrollment form				

# [100+] Employer/Group Application - Arkansas



FOR GROUP COVERAGE ([100+] ELIGIBLE EMPLOYEES)

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group/Employer Application as "Humana".

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company,].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company].]

[1-10]. EMPLOYER COMPANY INFORM	ATION:	Please type	or print clearl	y in black ir	lk Interr	nal use only	Group	number:	
Full legal business name								Requested e	ffective date
Corporate/Situs location street address (P.O. Box r	not allowe	d) City			State	ZIP code		County	
	☐ Sole Pr ☐ Other (					stablished	Feder	eral Tax ID	
Nature of business/SIC code	Busir (	ness phone )	number			Business fax	x numb	er	
Do you have more than one location? ☐ No	☐ Ye	S							
Benefit Administrator/Management contact	t name:								
Phone number ( )	Fax numb (	er )			E-	-mail			
Management contact: Mother's maiden name (this will be used to gain access to the Employer S	Self-Service	e Center on	ı www.Huma	ana.com)					
Billing contact name:									
Billing address (N/A, if same as street address)				City				State	ZIP code
Phone number ( )	Fax numb (	er )		1	E-	-mail			
[For Workplace Voluntary Benefits: Effective of Its property in the control of t	Prem	ium mode	: □ Monthl	y □ Qua	rterly $\square$	] Semi-Annua	al 🗆 A	nnual]	
	[All	[Medical	[Dental	[Life	[Vision	[STD	[LTD	[Group Critical Illness	
A. Number of hours worked per week to be eligible (select between [0-20] and [0-40] hours)									
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)									
C. Total number of eligible employees									
Number of employees:									_
<ul> <li>waiving with other qualifying coverage</li> </ul>									
waiving without other qualifying coverage	_	_							
Number of employees to be enrolled		]		]	]	]	]		]
Probationary waiting period for eligible employees (if you prefer months, please select "Other" and s	specify the	number of		□ 60 da		□ 90 days		ther (specify	
Employee effective provision: [(On all plans, excep STD/LTD is immediate.)]  [New	y waiting	period	. J □ Imm	ediately fo	llowing	cides with the probationary probationary	waitin	g period]	ovision.

[1-10]. ELIGIBILITY REQU						
Do you want to exclude a class of the second of the secon	ptions vary by	plan. Refer to the I	Jnderwriting Requir I non-management	rements for each pl		_
Employee Eligibility by Clas According to Federal health care may result in a penalty. To avoid plan does not favor highly comp	e reform, an er d penalties, ple pensated emple	ease review any cla oyees. (Excludes gr	ss-based benefits w andfathered health	rith your legal or fin plans).		
Has this group been insured by If yes, please provide prior group			rs? 🗆 No 🗆 \	⁄es		
Is this a Collectively Bargained F			e of Plan	// 1		(1) 100 ( 5500)
Plan number	Dawton au Cavana		□ Vaa	(Assigned by	Employer for use in	filing IRS form 5500)
Do you wish to offer Domestic F	artner Covera	ge? □ No	□ Yes			
Retiree information For groups 26+, are you offering	g coverage to i	retirees?   No	☐ Yes If yes, re	quired age	_ Minimum yea	ars of service
		All	Medical	Dental	Vision	Life (if applicable)
Number of current retirees to b	oe covered					
Does this company have any sultax return?   No  Yes If yes			e any other associat	ed entities that are	eligible to file a fec	
Company name						Total employees
[Group Term Life,] [Short Ter	rm Disability	,] [Long Term Dis	ability,] and [Gro	up Critical Illness	s] only	
Effective dates for changes	s in amounts	<u> </u>		up Critical Illness day of month fol		Other
Effective dates for changes Increases/decreases due to cha	s in amounts ange in class	<u> </u>		day of month fol		Other
Effective dates for changes Increases/decreases due to cha Increases/decreases requested	s in amounts ange in class by employee	of coverage		day of month fol		Other
Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins	s in amounts ange in class by employee	of coverage		day of month fol		Other
Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins Decreases due to age	s in amounts ange in class by employee urability) reque	ested by employee	Effective first of	day of month fol		Other
Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins	s in amounts ange in class by employee urability) reque	ested by employee	Effective first of the second	day of month fol	lowing change	
Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required	s in amounts ange in class by employee urability) reque	ested by employee coverage applied fo	Effective first of the control of exceeds amounts of exceeds amounts of the control of the contr	day of month fol	Class 1	Class 2
Effective dates for changes Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required Employee life	s in amounts ange in class by employee urability) reque  if amount of class 1	ested by employee coverage applied fo	Effective first of the second	day of month foll	Class 1	Class 2
Effective dates for changes Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required Employee life Employee STD	s in amounts ange in class by employee urability) reque	ested by employee  coverage applied for Start St	er exceeds amounts Spouse life Basic group	below:	Class 1	Class 2
Effective dates for changes Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required  Employee life Employee STD Employee LTD	s in amounts ange in class by employee urability) reque	ested by employee  coverage applied for  Class 2  \$	or exceeds amounts  Spouse life Basic group Buy-up grou	below:	Class 1	Class 2
Effective dates for changes Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required  Employee life Employee STD Employee LTD  Special requests: Check be [W-2 Services Option (Pleas Option 1: Withhold state and Option 2: Withhold federal in	s in amounts ange in class by employee urability) reque l if amount of c Class 1 \$ \$ ox and attach is e choose one d federal income	ested by employee  coverage applied for  Class 2  \$  \$  signed additional signet additional signet additional signet additional signet additional signet and the employee's	Effective first of the street of exceeds amounts  Spouse life Basic group Buy-up group heet or letter, if cust mployee's portion of portion of FICA. Ap	below:  critical illness p critical illness com dating, face and	Class 1 \$ shounts, etc. are desired file W-2 Forms.	Class 2 \$ \$ red.
Effective dates for changes Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required  Employee life Employee STD Employee LTD  Special requests: Check be [W-2 Services Option (Pleas Option 1: Withhold state and	s in amounts ange in class by employee urability) reque l if amount of c Class 1 \$ \$ ox and attach is e choose one d federal income	ested by employee  coverage applied for  Class 2  \$  \$  signed additional signet additional signet additional signet additional signet additional signet and the employee's	Effective first of the street of exceeds amounts  Spouse life Basic group Buy-up group heet or letter, if cust mployee's portion of portion of FICA. Ap	below:  critical illness p critical illness com dating, face and	Class 1 \$ shounts, etc. are desired file W-2 Forms.	Class 2 \$ \$ red.
Effective dates for changes Increases/decreases due to cha Increases/decreases requested Increases (with Evidence of Ins Decreases due to age Evidence of Insurability required  Employee life Employee STD Employee LTD  Special requests: Check be [W-2 Services Option (Pleas) Option 1: Withhold state and	s in amounts ange in class by employee urability) reque l if amount of c Class 1 \$ \$ ox and attach is e choose one d federal income come taxes, a 2 services elect h the above el	s of coverage ested by employee coverage applied for Class 2 \$ \$ \$ signed additional size) he taxes, and the elegand the employee's cited by applicant precion and establis	Effective first of the street of exceeds amounts  Spouse life Basic group Buy-up group heet or letter, if cust mployee's portion of portion of FICA. Ap	below:  critical illness p critical illness com dating, face and	Class 1 \$ shounts, etc. are desired file W-2 Forms.	Class 2 \$ \$ red.

[ ]. Godings Godings	••				
Is your group subject to: COBRA □ N	No ☐ Yes State Continua	ation 🗆 No	o □ Yes		
Number of existing COBRA participants	Medical:	Dental:		Vision:	
How many in COBRA election period	Medical:	Dental:		Vision:	
Are any present or former employees/depender If yes, enter information below. Attach addition				□ No □ Yes	
	Qualifying event (e.g. termina	ation of	Qualifying	COBRA/State	Continuation
Name of applicant	employment, divorce, etc.)		event date	Start date	End date

Coverage Employer's contribution for:	[Medical	[Dental	[Vision	[Life	[Voluntary Life	[STD	[BUY UP STD	[LTD	[BUY I		y Spending
Employee	%	%	%	%	%	%	%	%	9	6 %	\$
Employee/spouse	%	%	%	%	%	N/A	N/A	N/A	N/A	%	\$
Employee/child	%	%	%	%	%	N/A	N/A	N/A	N/A	%	\$
Family	%]	%]	%]	%]	%]	N/A]	N/A]	N/A]	N/A]	%]	\$
[1-10]. PRIOR/CURRENT C	ARRIER	INFORI	ΛΑΤΙΟΝ	ı							
			[Med	lical	[Dental	[	Life	[Visio	n	[STD	[LTD
Is this group transferring from an	other grou	p carrier?	□ No I	□ Yes	□ No □ Ye	s 🗆 N	o □ Yes	□No□	] Yes	□ No □ Yes	□ No □ Yes
If yes, provide carrier name											
Proposed termination date				]	]		]	]		]	]
[ <b>Dental only:</b> Did prior dental co	overage in	clude orth	odontia?	□No□	] Yes]						
[For Workplace Voluntary Ber					□ Individua	l ☐ Gr		verage te			]
[Disability income carrier[CI/Cancer carrier[T-10]. PRODUCT SELECTION our quote for the plan's name. Also a-g]. MEDICAL PLANS	ON - To o	complete t he Regula		n, please		. Underw	riting Rec		s (reord	er AR-52347).	Please refer to
[CI/Cancer carrier[1-10]. PRODUCT SELECTION our quote for the plan's name. Also	<b>ON -</b> To 0	complete t		n, please	e refer to the	e Underw e Guide v	vriting Recovith your a	uirement	s (reord	er AR-52347).	Please refer to
[CI/Cancer carrier	ON - To o	complete t he Regula		n, please	e refer to the	e Underwe Guide v	vriting Reconstitution:	uirement	s (reord	er AR-52347).	Please refer to
[CI/Cancer carrier	ON - To oso review t	complete the Regularies Yes	Tory Pre-€	n, please enrollme	Product s	e Underw e Guide v specificat specificat	vriting Rec with your a tion: tion:	juirement agent, bro	s (reord ker, or <sub> </sub>	er AR-52347).	
[CI/Cancer carrier] [1-10]. PRODUCT SELECTION (CONTROL OF THE PLANS) [a-g]. MEDICAL PLANS Is this a SmartSuite selection?  Product specification:  Product specification:  Product specification:  Health Care Flexible Spendin	ON - To one so review to the sound to the sheet of the sound to the sheet of the sh	Complete the Regula  ☐ Yes  (FSA)  duct spectage of 26 fpaper (re	☐ Dependent Dep	n, please enrollme endent C vered in -52422)	Product so	e Underwe Guide versions Specificate Specificate Spendin	vriting Recovith your attion: tion: tion: g Account	juirement agent, bro (FSD) Yes nt name, s	s (reord oker, or	er AR-52347). producer. alth Savings A	ccount (HSA)
[CI/Cancer carrier  [1-10]. PRODUCT SELECTION Our quote for the plan's name. Also [a-g]. MEDICAL PLANS  Is this a SmartSuite selection?  Product specification:  Product specification:  Product specification:  Product specification:  Are there any disabled dependent of the specification of the specifica	g Account the sheet of the last 90 ered by Meered by Mee	(FSA) duct spece age of 26 f paper (remployee all that ape atment fadical expece days to be dicare rel	Deperification: to be coorder GN employe individu ply) cility nses in the	endent C vered in -52422) ee and th al in a re disability	Product s existence of er existence class, of months hospitalized or End-Stag	e Underwe Guide version of the Country of the Count	viting Recovith your attion: tion: tion: g Account depender ier insurin nt (spouse	yes nt name, seg the dep or child)	s (reord leaves, or	er AR-52347). producer.  alth Savings A  nt of disability  A beneficiary, of  Yes  Yes  Yes  Yes  Yes	ccount (HSA) /diagnosis or individual

[1-10]. EMPLOYER CONTRIBUTION(S)

AR-71012-EA-LG 4/2012 3 Reorder# AR-52248-LG [4/2012]

[Health Que	estionnaire for gro	ups en	rolling [100	0+] employ	ees:	(check all that a	apply)				
1. Has any e	employee been unabl	le to wo	ork 10 or mor	e consecutive	day	s in the past 12	month	s due to an illness or	injury?		lo □ Yes
2. Is any em	ployee presently not	perforn	ning his or he	er duties on a	full-	time basis due	to an ill	ness or injury?			lo □ Yes
beneficia • confir	ry, or individual withined at home, in a home.	COBRA/State r in a treatme	any employee, individual in a retiree class, dependent (spouse or child), COBRA BBRA/State Continuation election period:  n a treatment facility  medical expenses in the past 24 months					COBRA		lo □ Yes lo □ Yes	
						4				lo 🗆 Yes	
4. To the be individual	st of your knowledge I within their COBRA	e, is the /State C	re any employ Continuation	st 90 days to have surgery or be hospitalized any employee, individual in a retiree class, dependent (spouse or child ntinuation election period who received treatment, had treatment reco chologist or other licensed practitioner within the past 24 months for a				had treatment recom	mended, or	had med	
	OS or an AIDS-related nune system disorde		ex or other	□ No □	Yes	• Diabetes kidneys, l		disease or disorder of ungs	the	□No	□ Yes
	ohol or drug abuse c chological disorder	or deper	ndence, or	□ No □	Yes			including, but not lin		□No	☐ Yes
• Car	ncer or cancerous tur	mor		□ No □	Yes	Heart or	vascular	disease or stroke		□No	☐ Yes
• Org	gan transplant (other	than co	orneal)	□ No □	Yes						
	red yes to questions 52334), if necessary.		ve, please inc	dicate the qu	estio	n number and e	explanat	ion. Attach additiona	l signed an	d dated s	heets
Question #	Member Status*	Age	Medical Co Diagnosis	ondition/		ate(s) of reatment	Medic Dosag	ation Name/ Je	Past/Curr Treatmer		ure
* Member Stat	tus: E=Employee D	=Depend	dent C=COE	3RA/State Con	tinua	tion R=Retiree	Class				
	npany, at any time du s If yes, please expla		e past 24 moi	nths, had me	dical	coverage termi	nated o	r a renewal of medica	al coverage	refused?	
								ner other than health cable time period up			payment?
[ <mark>a-g</mark> ]. DEN	TAL PLANS (all gr	oup size:	s)								
			Plan 1					Plan 2			
Plan name	(as shown on your pi	roposal)									
Funding type			1 ,	er sponsored		☐ Voluntary		☐ Employer sponso	ored 🗆	Voluntary	/
Coinsurance			In%	1 1	Out	% /	1	In% / /	Out	_% /	/ /
Deductible			In \$		Out	\$		In \$	Out \$		
Annual maxir	mum		\$					\$			
										1 1	

	Plan 1	Plan 2
Plan name (as shown on your proposal)		
Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Coinsurance	In% / / Out% / /	In% / / Out% / /
Deductible	In \$ Out \$	In \$ Out \$
Annual maximum	\$	\$
Preventive services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible
Periodontic/Endodontic options	☐ Basic ☐ Major	☐ Basic ☐ Major
Composite fillings for molars	□ No □ Yes	□ No □ Yes
Implant coverage	□ No □ Yes	□ No □ Yes
Orthodontia options	☐ Child only: lifetime ortho max \$ ☐ Adult & child: lifetime ortho max \$	☐ Child only: lifetime ortho max \$ ☐ Adult & child: lifetime ortho max \$
Out of network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedule
[Oral Surgery Covered in Basic	□ No □ Yes	□ No □ Yes]
Open Enrollment	□ No □ Yes	

[a-g	]. LIFE	(all group sizes) - Please refer t	o your proposal	
			D only applicable to certain plans)	
			Increment (if applicable) \$	- vlavali
			lary, rounded to the next highest \$1,000. Indicate salary imes between the classes and 10 times between the lov	
	Class	<b>Description</b>	mics between the dasses and 10 times between the lov	Benefit Amount / Salary Factor
	L	Description		benefit Amount / Sulary Fuctor
	ll .			
	III			
	IV			
			1: I ) E2V E2V	
		` *	certain plans) ☐ 2 Year ☐ 3 Year	
Age	• <b>Keduct</b> vou are a	ion (only available with only selecting Voluntary Life A	c <b>ertain plans)</b> Age Reduction, age reduction values between Basic Emp	plovee and Voluntary Life must match.
	•	•		,
Basi			If yes, indicate volume amount \$20,000/\$5,000	□ \$10,000/2,500 □ \$5,000/\$1,000
Volu		ployee Life □ No □	Yes If yes, do you want to select AD&D? ☐ No when enrolled in Voluntary Life) ☐ No	
		tion (only available with also selecting Basic Employee	<b>certain plans)</b> e Age Reduction, age reduction values between Basic Er	nployee and Voluntary Life must match.
[Port	tability of	coverage (Applicable to Vol	untary Life only)	
[a-g	]. VISIO	ON PLANS (all group sizes)		
			Plan 1	Plan 2
Plan	name (a	s shown on your proposal)		
Visio	n Optio	ns (For groups 100+ with a cus	stom vision plan, please list the in-network benefit options bel	ow.)
Func	ding type		☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Exan	n / mater	ial copayment	/	/
Fram	ne allowa	nce		
Cont	tact lens	allowance		

Frequency

AR-71012-EA-LG 4/2012 5 Reorder# AR-52248-LG [4/2012]

[a-q]. SHORT TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336), if necessary. Name of Class 1 ☐ Contributory ☐ Non-contributory Funding type □ Voluntary □ 50% □ 60% □ 66.67% ☐ Other \_\_\_\_\_ ☐ Flat amount \$ \_\_\_\_ Benefit schedule (select one) ☐ Incremental amount \$ Weekly benefit minimum \$ Weekly benefit maximum \$ ☐ Base salary ☐ Average \_\_\_\_\_ months bonus ☐ Average months commission Earnings definition ☐ Other **Duration** weeks □ 13 □ 26 □ 52 ☐ Other Elimination period (accident/sickness) □ 1/8 □ 8/8 □ 15/15 □ 30/30 ☐ Other Pre-existing limitation □ 3/3/12 ☐ None □ Other Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for days Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for days ☐ 2 Years ☐ Other Rate guarantee ☐ 1 Year Name of Class 2 Funding type □ Contributory ☐ Non-contributory □ Voluntary □ 60% □ 66.67% ☐ Other ☐ Flat amount \$ Benefit schedule (select one) ☐ Incremental amount \$ Weekly benefit minimum \$ Weekly benefit maximum \$ ☐ Base salary ☐ Average \_\_\_\_\_ months bonus ☐ Average \_\_\_\_\_ months commission Earnings definition ☐ Other **Duration** weeks □ 13 □ 26 ☐ 52 ☐ Other Elimination period (accident/sickness) □ 1/8 □ 8/8 □ 15/15 □ 30/30 □ Other \_ Pre-existing limitation ☐ None □ 3/3/12 ☐ Other Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for \_ days Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for \_ days Rate quarantee ☐ 1 Year ☐ 2 Years ☐ Other \_ [a-g]. LONG TERM DISABILITY (group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336), if necessary. Name of Class 1 Funding type ☐ Contributory ☐ Non-contributory ☐ Voluntary Benefit schedule (select one) □ 50% □ 60% □ 66.67% ☐ Other ☐ Incremental amount \$ □ \$100 or 10% of monthly salary Monthly benefit minimum ☐ Other \$ Monthly benefit maximum ☐ Base salary ☐ Average \_\_\_\_ \_\_ months bonus □ Average \_\_\_\_\_ months commission Earnings definition ☐ Other Duration ☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other \_\_ Elimination period Days: □ 30 □ 60 □ 90 □ 180 □ Other \_ Definition of disability Year own occupation:  $\square$  2  $\square$  3 ☐ to age 65 □ Other Pre-existing limitation □ 3/3/12 □ 6/6/12 □ 3/12 □ 6/12 ☐ Other Mental health and substance abuse ☐ 24-month outpatient ☐ 12-month outpatient ☐ Other \_\_\_ limitation Waiting period: current employees ☐ Eligible on date of employment ☐ Eligible after active employment for \_ days Waiting period: rehired/new employees ☐ Eligible on date of employment ☐ Eligible after active employment for days Rate quarantee ☐ 1 Year ☐ 2 Years ☐ Other

AR-71012-EA-LG 4/2012 6 Reorder# AR-52248-LG [4/2012]

# [a-g]. LONG TERM DISABILITY (group sizes 10+) (continued)

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	□ 50% □ 60% □ 66.67% □ Other □ Incremental amount \$
Monthly benefit minimum	□ \$100 or 10% of monthly salary □ Other
Monthly benefit maximum	\$
Earnings definition	☐ Base salary ☐ Average months bonus ☐ Average months commission ☐ Other
Duration	□ 2 Years □ 5 Years □ SSNRA □ Other
Elimination period	Days: □ 30 □ 60 □ 90 □ 180 □ Other
Definition of disability	Year own occupation: □ 2 □ 3 □ to age 65 □ Other
Pre-existing limitation	□ 3/3/12 □ 6/6/12 □ 3/12 □ 6/12 □ Other
Mental health and substance abuse limitation	□ 24-month outpatient □ 12-month outpatient □ Other
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other
<b>Additional benefits</b> : Please refer to your p GN-52336), if necessary.	roposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder
Cost of living adjustment (3%)	□ No □ Yes If Yes, □ Lesser of 3% or 1/2 CPI □ Lesser of 6% or 1/2 CPI Select number of adjustments □ 5 □ 10
Activities of daily living	□ No □ Yes If Yes, Additional maximum amount □ 10% □ 20% □ 30% □ 40%
Business income protection	□ No □ Yes If Yes, □ 15% to \$2,500 □ 25% to \$5,000
Special conditions limitation	□ No □ Yes If Yes, □ None □ 12 months □ 24 months
Survivor income benefit	(2-99) ☐ 3-month gross lump sum ☐ 6-month gross lump sum (100+ only) ☐ No ☐ Yes If yes, ☐ 3-month gross lump sum ☐ 6-month gross lump sum
Infectious & contagious disease	□ No □ Yes If Yes, Waiting period: □ 6 months □ 12 months  Earnings loss: □ 20% □ 40%  Duration of benefits: □ 2 Years □ 3 Years □ 4 Years □ Duration of claim  Benefits cease if earnings exceed: □ 80 % □ 60 %
Accidental dismemberment and loss of sight	□ No □ Yes If Yes, Loss occurs within: □ 90 Days □ 180 Days □ 365 Days
Extended earnings	□ No □ Yes If Yes, Qualification for benefit: □ Less than 60% of PDE □ Less than 80% of PDE □ Less than 100% of PDE □ Less than 80% of PDE □ Less than 100% of PDE □ Less
Pension contribution	□ No □ Yes
Medical premium supplemental	□ No □ Yes If Yes, Duration of Benefits: □ 2 Years □ 3 Years □ 4 Years □ 5 Years □ Duration of claim

	[a-g]. WORKPLACE VOLUNTARY BEN	<b>EFITS</b> (all group sizes)
	[DISABILITY INCOME PLUS] [ No Ye	s] [Plan design] [ Benefits are provided in conjunction with an HSA plan] [ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
	[Elimination period (select all that apply)] $[\Box [\Box ]$	1-24] Months] [
	[Optional Benefits - Employer Selectable]	[□ Loss of work] [□ 24-hour coverage] [□ Takeover] [□ Mental, nervous, alcohol and drug abuse] [□ Portability] [□ Sickness elimination period waiver (available only if 7- or 14-day elimination period is selected for sickness)]
	[Optional Benefits - Employee Selectable]	[□ COBRA benefit] [□ Physical Therapy] [□ ICU/CCU]
		[0-730] / [0-730]] [ [ [0-730] / [0-730]] [ [ [0-730] / [0-730]] [ [ 0-730] / [0-730]] [ [ 0-730] / [0-730]] [ [ 0-730] / [0-730]] [ [ 0-730] / [0-730]] [ [ 0-730] / [0-730]]
		24-hour coverage] [ Hospital confinement] [ Takeover]  COBRA] [ Limited mental health/Emotional disease  (only available with EP 0/14, 14/14, or 30/30)]
		[0-730] / [0-730]] [ [ [0-730] / [0-730]] [ [
	[Benefit period (select all that apply)] $\Box$	[1-90] Days] [ [1-24] Months] [ [1-2] Years] [ [1-2] Years] Emergency Accident] [ Outpatient Sickness] [ Hospital Indemnity]
		ndividual] [ <b>Base Plan]</b> [ Level 1] [ Level 2] [ Level 3] [ Level 4] an IRS-qualified pre-tax plan]
	with all plans.)	
	[CRITICAL ILLNESS] [□ No □ Yes]	[Plan design] [☐ Benefits are provided in conjunction with an HSA plan] [☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
	[Coverage choices]	[☐ Vascular] [☐ Cancer] [☐ Other critical illnesses [50 or] 100% of face amount]
		[□ Benefit recurrence] [□ Loss of work] [□ Takeover]
		[ Health screening benefit \$] [ Automatic benefit increase]]
	[CRITICAL ILLNESS (Employer paid)] [Coverage choices] [Optional Benefits - Employer Selectable]	[Plan design]       □ Benefits offered in conjunction with an IRS-qualified pre-tax plan]         [□ Vascular]       □ Cancer]       □ Other group critical illness [50 or] 100% of face amount]         [□ None]       □ Benefit recurrence]         [□ Takeover       □ Health screening: ] [□ \$50]       □ \$100]       □ \$150]       □ \$1-500]
	[Face amount (employee/member)] [Family options]	[□ Loss of work]   [□ Class   Basic: \$] [□ Class   Buy-up/Optional: \$]   [□ Class   Buy-up/Optional: \$] [□ Class   Buy-up/Optional: \$]   [□ Spouse Basic: \$ or% [□ Buy-up/Optional: \$ or%
	[Maximum benefit amount]	of employee/member amount]  [ Child(ren) Basic: \$ or% [ Buy-up/Optional: \$ or% of employee/member amount]  [ Basic: \$] [ Buy-up/Optional: \$]
- 1		* * *

### [a-q]. WORKPLACE VOLUNTARY BENEFITS (continued)

	[CRITICAL LIFE] [□ No □ Yes]	[ [1-	45] [Day(s)][Month(s)][Yeal 45] [Day(s)][Month(s)][Yeal		][Month(s)][Year(s)]] ][Month(s)][Year(s)]]				
	[Optional Benefits - Employer Selectab	[□ Additional benefit i	]	iving benefit - critical illn					
	[CANCER] [☐ Cancer Expense] [☐ C [☐ Benefits will be offered in conjunction w		plan]						
	[Optional Riders - Cancer Expense]		nity] [□ Lump sum first dia	agnosis]					
	[Optional Benefits - Group Lump Sum (				[□ Takeover benefit]				
	[Optional Benefits - Group Lump Sum Cancer Employee selectable] [  Health Screening \$]  Automatic benefit increase]								
			[L. Automatic ber	lefit increase]					
	[WHOLE LIFE] [☐ Whole Life 65] [☐ Waiver of premium ☐ Employee Term to		[□ Whole ss of work] [□ Automa	Life 99] atic benefit increase] [[	☐ Family Term]				
	[HEALTH CARE PLUS] [Hospital Confinement Benefit] [□ \$250] [□ \$500] [□ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan] [Optional Riders] [□ Hospital Indemnity]								
	[SUPPLEMENTAL HEALTH] [ No Yes	] [  Benefits will be offered	ed in conjunction with an II	RS-qualified pre-tax plan]					
L	[Base plan]	[□ Plan A]	[□ Plan B]	[□ Plan C]	[□ Plan D]				
	[Hospital Indemnity] [Hospital First Occurrence]	[\$100/day] [\$250/day]	[\$200/day] [\$500/day]	[\$300/day] [\$500/day (days 1-2)] [\$750/day (days 3-4)]	[\$500/day] [\$500/day (days 1-2)] [\$1,000/day (days 3-4)]				
	[Optional benefits - Employer selectab	le]							
	[ Emergency Room]	[\$50/day (ER)] [\$40/day (urgent care)]	[\$100/day (ER)] [\$80/day (urgent care)]		[\$250/day (ER)] [\$200/day (urgent care)]				
	[□ ICU/CCU/Burn Unit benefit]	[\$100/day]	[\$200/day]	[\$600/day]	[\$1,000/day]				
	☐ Surgical Schedule]	[\$500]	[\$1,000]	[\$1,000]	[\$2,000]				
	[ Diagnostic, laboratory and x-ray]	[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$50/test (hospital)] [\$40/test (doctor's office or clinic)]	[\$75/test (hospital)] [\$60/test (doctor's office or clinic)]				
	[ Outpatient office visit]	[\$25]	[\$50]	[\$75]	[\$100]				
	[ Wellness]	[\$50]	[\$50]	[\$100]	[\$150]				
	[If multiple plans are selected and plan avail-	ability is limited by class, pl	ease list what class of emp	loyees are eligible for each	ch plan.]				

### [1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4) resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

### [1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility,

underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

AR-71012-EA-LG 4/2012 9 Reorder# AR-52248-LG [4/2012]

### [1-10]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree, and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. Neither you nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Dated on:	(month, date, year) at			(city and state)	
				, ,	
3y:(Employer printed name)	(Employer s	ignature)	(T	itle)	
or Workplace Voluntary Benefits - only necessary	for non-employer grou	OS.			
By:(Plan sponsor printed name)	(8)				
(Plan sponsor printed name)	(Plan sponso	r signature)	(1	ïtle)	
I-10]. AGENT/BROKER/PRODUCER IN	FORMATION				
I. Agency of Record (for commissions and	correspondence)	2. Agent/Agency of Re	ecord (for split co	mmissions)	
Name (print or type)		Name (print or type)			
ax ID/Social Security Number/Humana Agent Nu	mber	Tax ID/Social Security Number/Humana Agent Number			
Commission split $\ \square$ No $\ \square$ Yes If yes, percentage: (total	should equal 100%)	Commission split \( \square\) No If yes, percentage:		total should equal 100%	
. Writing Agent/Broker/Producer		2. Writing Agent/Brok	er/Producer		
lame (print or type)		Name (print or type)			
Social Security Number/Humana Agent Number		Social Security Number/H	lumana Agent Numb	per	
Commission split □ No □ Yes If yes, percentage: (total	should equal 100%)	Commission split \( \simeg \) No If yes, percentage:		total should equal 100%	
eneral Agency (Complete only if agency in	volved in sale)				
eneral agency information pertains to: $\Box$ Ag	gency of Record $\Box$	Writing Agent			
ame (print or type)		Tax ID/Humana Agent Nเ	ımber		
ddress		City	State	ZIP code	

AR-71012-EA-LG 4/2012 10 Reorder# AR-52248-LG [4/2012]

# [2-99] Employer/Group Application - Arkansas



FOR GROUP COVERAGE ([2-99] ELIGIBLE EMPLOYEES)

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group/Employer Application as "Humana". [Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company].]

☐ First of month following probationary waiting period

[Rehire

[1-10]. **EMPLOYER COMPANY INFORMATION:** Please type or print clearly in black ink | Internal use only Group number: Requested effective date Full legal business name Corporate/Situs location street address (P.O. Box not allowed) ZIP code State County ☐ Partnership Type of ☐ Corporation ☐ Sole Proprietorship Date company established Federal Tax ID business ☐ Church or Government entity ☐ Other (explain) Nature of business/SIC code Business phone number Business fax number  $\square$  No Do you have more than one location? □ Yes Benefit Administrator/Management contact name: Phone number Fax number E-mail Management contact: Mother's maiden name (this will be used to gain access to the Employer Self-Service Center on www.Humana.com) Billing contact name: Billing address (N/A, if same as street address) City State ZIP code Phone number Fax number E-mail [Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.] [For Workplace Voluntary Benefits: Effective date of policy and due date of first premium will be (month, day, year) / / [1-10]. ELIGIBILITY REQUIREMENTS \_. An employee who is eligible to apply for insurance is one who is actively at work on a full-time basis Number of employees on payroll working at least the number of hours per week as indicated in the table below. Workplace Group Critical Voluntary All [Medical | Dental Life Vision STD **LTD** Illness **Benefits** A. Number of hours worked per week to be eligible (select between [0-20] and [0-40] hours) B. Number of employees in a probationary waiting period (do not include in the eligible count below in C) C. Total number of eligible employees As of the date of this application, list any employees currently disabled and not actively at work: (attach additional signed and dated pages, if necessary) Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify) (if you prefer months, please select "Other" and specify the number of months) Employee effective provision: [(On all plans, except STD and LTD, the employee termination date coincides with the effective date provision. STD/LTD is immediate.)] ☐ First of month following probationary waiting period ☐ Immediately following probationary waiting period]

☐ Immediately following probationary waiting period

[1-10]. ELIGIBILITY REQU	JIREMENT:	(continued)							
Do you want to exclude a class If yes, check class to exclude: (O ☐ union ☐ non-union ☐ he	ptions vary by	y plan. Refer to the							
Employee Eligibility by Clas According to Federal health car may result in a penalty. To avoid plan does not favor highly comp	e reform, an e d penalties, p	lease review any cla	ss-based benefits	with your lea					
Has this group been insured by If yes, please provide prior grou			nrs? □ No □	□ Yes					
Is this a Collectively Bargained I Plan number	Plan? □ N	lo □ Yes Nam	e of Plan	(Assi	gned by Em	ployer 1	for use ir	n filing II	RS form 5500)
Do you wish to offer Domestic F	artner covera	ige? □ No	☐ Yes						
Retiree information									
For groups 26+, are you offering	g coverage to	retirees? □ No	☐ Yes If yes,	required age		Mini	mum yea	ars of se	rvice
		All	Medical	Dei	ntal	٧	ision	Li	<b>fe</b> (if applicable)
Number of current retirees to be	e covered								
Does this company have any sultax return?   No Yes If ye			e any other assoc	iated entities	that are eli	gible to	file a fee	deral or	state combined
Company name	·							Tota	l employees
Company name								1000	
[Short Term Disability,] [Lon	g Term Disa	bility,] and [Group	Critical Illness	s] only					
Effective dates for change	s in amount	s of coverage	Effective firs	t day of mo	nth follo	wing ch	nange		Other
Increases/decreases due to cha									
Increases/decreases requested	by employee								
Increases (with Evidence of Ins	urability) reqเ	uested by employee							
Decreases due to age									
Evidence of Insurability required	if amount of	coverage applied for	or exceeds amoun	its below:					
	Class '	1 Class	2			Cla	ass 1		Class 2
Employee STD	\$	\$		up critical illn		)		\$	
Employee LTD	\$	\$	Buy-up gr	roup critical il	Iness				
☐ <b>Special requests:</b> Check be	ox and attach	signed additional s	heet or letter, if c	ustom dating	, face amοι	ınts, etc	. are des	ired.	
<ul> <li>[W-2 Services Option (Pleas</li> <li>□ Option 1: Withhold state and</li> <li>□ Option 2: Withhold federal in</li> <li>A detailed description of the Webe performed in accordance with</li> </ul>	d federal inco	me taxes, and the e	mployee's portior	n of FICA Pre					
		' '	•	Applicant wa	ives W-2 fo	rms ser	vices.	a mail. S	uch services will
[1-10]. COBRA/STATE CO	2 services ele h the above e	ected by applicant pelection and establis	ursuant to this Ар hed as standard p	Applicant wa pplication will procedures.]	ives W-2 fo be sent to	orms ser the app	vices.	a mail. S	iuch services will
[1-10]. COBRA/STATE CO  Is your group subject to:	2 services ele h the above e	ected by applicant p election and establis	ursuant to this Aphed as standard p	Applicant wa oplication will procedures.]	ives W-2 fo be sent to	orms ser the app	vices. olicant via		uch services will
[1-10]. COBRA/STATE CO  Is your group subject to:  Number of existing COBRA part	2 services ele h the above e  NTINUATI  COBRA   icipants	ected by applicant pelection and establis  ON  No	State Continua	Applicant wa pplication will procedures.]  ation	ives W-2 fo be sent to	orms ser the app	vices. olicant via		uch services will
[1-10]. COBRA/STATE CO  Is your group subject to:  Number of existing COBRA part How many in COBRA election p	2 services ele h the above e  NTINUATI  COBRA  icipants  eriod	ected by applicant pelection and establis  ON  No	State Continua	Applicant wa pplication will procedures.]  Ition Note that the procedure Note that the pental:  Dental:	be sent to	orms ser the app	vices. olicant via		iuch services will
[1-10]. COBRA/STATE CO  Is your group subject to:  Number of existing COBRA part	2 services ele h the above e NTINUATION COBRA Inicipants eriod byees/depend	No Yes Medical: Medical: ents currently on or	State Continua	Applicant wa oplication will procedures.]  ation	be sent to	orms ser the app	vices. olicant via		uch services will
[1-10]. COBRA/STATE CO  Is your group subject to:  Number of existing COBRA part  How many in COBRA election p  Are any present or former emplo	2 services ele h the above e NTINUATION COBRA Inicipants eriod byees/depend	No Yes  Medical:  Medical:  ents currently on or onal signed and date	State Continua eligible to elect Ced sheets (reorder	Applicant wa pplication will procedures.]  Ition No Dental: Dental: COBRA/State r AR-52247),	be sent to  D Ye  Continuation if necessary	the app	vices.  licant via  Vision:  Vision:	∵ □ Yes	iuch services will
[1-10]. COBRA/STATE CO  Is your group subject to:  Number of existing COBRA part  How many in COBRA election p  Are any present or former emplo	2 services ele h the above e NTINUATION COBRA Inicipants eriod byees/depend	No Yes  Medical:  Medical:  ents currently on or onal signed and date	State Continua eligible to elect Ced sheets (reorder	Applicant wa pplication will procedures.]  Ition No Dental: Dental: COBRA/State r AR-52247),	be sent to	the app	vices.  licant via  Vision:  Vision:	□ Yes	
[1-10]. COBRA/STATE CO  Is your group subject to:  Number of existing COBRA part  How many in COBRA election p  Are any present or former emplored in the company of the co	2 services ele h the above e NTINUATION COBRA Inicipants eriod byees/depend	No Yes Medical: ents currently on or onal signed and date	State Continua eligible to elect Ced sheets (reorder	Applicant wa pplication will procedures.]  Ition No Dental: Dental: COBRA/State r AR-52247),	be sent to  D Ye  Continuation if necessary	the app	vices.  Vision:  Vision:  No [	□ Yes	Continuation

(STD and LTD only) Are employer	contributions	taxed in en	nployee's payc	heck? 🗆 No	o □ Yes]						
Coverage - Employer's contribution for:	[Medical	[Dental	[Vision	[Life	Voluntary Life	[ST	D	[LTD	Vol	rkplace untary nefits	Spending Account*
Employee	%	%	%	%	%		%		%	%	\$
Employee/spouse	%	%	%	%	%	N/	А	N/A		%	\$
Employee/child	%	%	%	%	%	N/	А	N/A		%	\$
Family	%]	%]	%]	%]	%]	N/A	4]	N/A]		%]	\$
			Medical	Dental	[Li	ıe	V	ision	[S1	י עו	[LTD
Is this group transferring from ar	nother group	carrier?	□ No □ Yes	-			<u> </u>	o 🗆 Yes	□ No		□ No □ Ye
Is this group transferring from ar If yes, provide carrier name	nother group	carrier?		-			<u> </u>	o □ Yes	□ No		
If yes, provide carrier name Proposed termination date			□ No □ Yes	□ No □ Y			<u> </u>	o □ Yes ]	□ No		
If yes, provide carrier name			□ No □ Yes	□ No □ Y			<u> </u>	o □ Yes ]	□ No		
If yes, provide carrier name Proposed termination date	coverage inclu	ide orthodoi	No Yes    No	□ No □ Y	ryees	☐ Yes ] Cov	N □ N	o □ Yes  ]  terminat terminat	ion date	☐ Yes	□ No □ Yes
If yes, provide carrier name Proposed termination date  [Dental only: Did prior dental of  [For Workplace Voluntary Be  [Disability income carrier	coverage inclu	ide orthodoi	No Yes    No	No Y    Yes]  e to emplo   Individual   Individual	ryees	☐ Yes ] Cov	N □ N	] terminat	ion date	☐ Yes	□ No □ Yes
If yes, provide carrier name Proposed termination date [Dental only: Did prior dental of prior dental only)  [For Medical only]	coverage inclu	ide orthodoi	□ No □ Yes  □ No □ Yes  ntia? □ No □  rage availabl □ □	No Y    Yes]  e to emplo   Individual   Individual	ryees	Yes    Cov	N □ N	] terminat terminat	ion date	☐ Yes ☐	□ No □ Yes
If yes, provide carrier name Proposed termination date [Dental only: Did prior dental of prior dental only)  [For Medical only]	coverage inclu	ide orthodoi	No Yes  Intia? No Group's renev	No Y  Yes]  e to emplo Individual Individual val date:	ryees Group	Yes  Cov Cov	verage	] terminat terminat	ion date	Yes ]	□ No □ Yes

[1-10]. **PRODUCT SELECTION** - To complete this section, please refer to the Underwriting Requirements (reorder AR-52347). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

Prescription drug benefit \$

Spouse \$

Child(ren) \$

Family \$

### [a-i]. MEDICAL PLANS

Emergency room copay \$

Employee \$

How many medical carriers have you had in the past five years?]

**Renewal rates** 

[a-i]. MILDICAL PLANS															
	Plan	1				Plan	2				Plan	3			
Plan name (as shown in your proposal)															
Office/Specialist copay (if applicable)	\$		/ \$			\$		/ \$			\$		/ \$		
Coinsurance	In		% / Out		%	In		% / Out		%	In		% / Out		%
Deductible	In \$		/ Out	\$		In \$		/ Out	\$		In \$		/ Out	\$	
Out-of-pocket limit	In \$		/ Out	\$		In \$		/ Out	\$		In \$		/ Out	\$	
Prescription drug/Retail card (Level 1 / 2 / 3 / 4)	\$	/\$	/\$	/	%	\$	/\$	/\$	/	%	\$	/\$	/\$	/	%
Prescription drug/Retail card - RxImpact (Group A / B / C / D)	\$	/\$	/\$	/\$		\$	/\$	/\$	/\$		\$	/\$	/\$	/\$	
Network name															

### [a-i]. MEDICAL PLANS (continued)

**Additional riders:** Please refer to your proposal for rider availability with plan selected.

Deductible Carryover Credit Supplemental Accident [Employee Assistance Program Other: Special State Options:		□ No	☐ Yes	Plan 2	☐ Yes	Plan 3	☐ Yes	
Supplemental Accident [Employee Assistance Program Other:				□ No	☐ Yes	□ No	☐ Yes	
[Employee Assistance Program Other:		□ No						
Other:	.1 1		☐ Yes	□ No	☐ Yes	□ No	☐ Yes	
	ו וני	[□ No	☐ Yes]	[□ No	☐ Yes]	[□ No	☐ Yes]	
Special State Options:		□ No	☐ Yes	□ No	☐ Yes	□ No	☐ Yes	
Optional Behavioral Health Benefit	[	□ No	☐ Yes	□ No	☐ Yes	□ No	□ Yes	
<b>Workers' Compensation</b> (a Do you wish to have 24-hour If yes, name(s):					nsation? 🗆 No 🗆	Yes		
[Health Questionnaire for	groups er	nrolling	[2-99] employee	es: (check all that a	apply)			
1. Has any employee been ur	•	_				ess or injury?	□ No □ Yes	
2. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury? ☐ No ☐ Yes								
2. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury?								
If you answered yes to questic (reorder GN-52334), if necess								
Question # Member Statu	ıs* Age	Medica Diagno	l Condition/ sis	Date(s) of Treatment	Medication Name/ Dosage	Past/Curi Treatmer	rent/Future nt	
* Member Status: E=Employee	D=Depen	dent C=	-COBRA/State Conti	nuation R=Retiree	Class			
Has your company, at any time  ☐ No ☐ Yes If yes, please e		e past 24	months, had med	lical coverage term	inated or a renewal of	medical coverage	refused?	
	1.1.1	the nest	24 months boon	funded by you in a	ny manner other than	haalth incurance		

AR-71012-EA-SB 4/2012 4 Reorder# AR-52248-SB [4/2012]

[a-i].	DENTAL	<b>PLANS</b>	(all	group	sizes

	Plan 1	Plan 2					
Plan name (as shown on your proposal)							
Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary					
Coinsurance	In% / / Out% / /	In% / / Out% / /					
Deductible	In \$ Out \$	In \$ Out \$					
Annual maximum	\$	\$					
Preventive services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible					
Periodontic/Endodontic options	☐ Basic ☐ Major	☐ Basic ☐ Major					
Composite fillings for molars	□ No □ Yes	□ No □ Yes					
Implant coverage	□ No □ Yes	□ No □ Yes					
Orthodontia options	☐ Child only: lifetime ortho max \$ ☐ Adult & child: lifetime ortho max \$	☐ Child only: lifetime ortho max \$ ☐ Adult & child: lifetime ortho max \$					
Out of network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedule					
[Oral Surgery Covered in Basic	□ No □ Yes	□ No □ Yes]					
Open Enrollment	□ No □ Yes						
[a-i]. LIFE - Please refer to your proposal  Basic Life							
Basic Employee Life and AD&D □ No □ Yes □ Flat amount—indicate level: \$ □ Salary plan—options are .5x to 7x salary (in .5 increments), rounded to the next highest \$1,000. Indicate salary level: x salary Maximum benefit \$							
	mas between the classes and 10 times between the	owest and highest class (semplete table helew)					
	mes between the classes and 10 times between the l	Choose Flat Amount or Salary Level					
Class schedule—no more than 2.5 ti	mes between the classes and 10 times between the l						
☐ Class schedule—no more than 2.5 ti	mes between the classes and 10 times between the l	Choose Flat Amount or Salary Level					
Class schedule—no more than 2.5 ti  Class Description  1. 2. 3.	mes between the classes and 10 times between the l	Choose Flat Amount or Salary Level					
Class schedule—no more than 2.5 ti  Class Description  1. 2.	mes between the classes and 10 times between the l	Choose Flat Amount or Salary Level					
Class schedule—no more than 2.5 ti  Class Description  1. 2. 3.	ar Schedule 1 Schedule 2	Choose Flat Amount or Salary Level (Must match for all classes)					
Class schedule—no more than 2.5 ti  Class Description  1. 2. 3. 4.  Rate Guarantee	ar Schedule 1 Schedule 2	Choose Flat Amount or Salary Level (Must match for all classes)					
Class schedule—no more than 2.5 ti  Class Description  1. 2. 3. 4.  Rate Guarantee    2 Year   3 Yea Age Reduction (Refer to your proposal) Basic and Voluntary Age Reduction schedu Basic Dependent Life    No If yes, indicate volume amount  Spouse \$20,000; Dependent Age	ar Schedule 1 Schedule 2 ules must match. □ Yes e 6 Months to 26 Years \$5,000, Dependent Age 15	Choose Flat Amount or Salary Level (Must match for all classes)  Schedule 3					
Class schedule—no more than 2.5 ti  Class Description  1. 2. 3. 4.  Rate Guarantee	ar Schedule 1 Schedule 2 ules must match.  □ Yes  e 6 Months to 26 Years \$5,000, Dependent Age 15   14 Days No Benefit e 6 Months to 26 Years \$2,500, Dependent Age 15	Choose Flat Amount or Salary Level (Must match for all classes)  Schedule 3  Days to 6 Months \$1,000,					
Class schedule—no more than 2.5 ti  Class Description  1. 2. 3. 4.  Rate Guarantee	ar Schedule 1 Schedule 2  Jles must match.  Yes  e 6 Months to 26 Years \$5,000, Dependent Age 15 14 Days No Benefit e 6 Months to 26 Years \$2,500, Dependent Age 15 14 Days No Benefit e 6 Months to 26 Years \$1,000, Dependent Age 15 12	Choose Flat Amount or Salary Level (Must match for all classes)  Schedule 3  Days to 6 Months \$1,000,					
Class schedule—no more than 2.5 ti  Class Description  1. 2. 3. 4.  Rate Guarantee	er Schedule 1 Schedule 2  Jles must match.  Yes  e 6 Months to 26 Years \$5,000, Dependent Age 15 11 12 12 12 12 12 12 12 12 12 12 12 12	Choose Flat Amount or Salary Level (Must match for all classes)  Schedule 3  Days to 6 Months \$1,000, Days to 6 Months \$500,					
Class schedule—no more than 2.5 ti  Class Description  1. 2. 3. 4.  Rate Guarantee	ar Schedule 1 Schedule 2  Jles must match.  Yes  e 6 Months to 26 Years \$5,000, Dependent Age 15 14 Days No Benefit e 6 Months to 26 Years \$2,500, Dependent Age 15 14 Days No Benefit e 6 Months to 26 Years \$1,000, Dependent Age 15 14 Days No Benefit e 6 Months to 26 Years \$1,000, Dependent Age 15 12 Days No Benefit	Choose Flat Amount or Salary Level (Must match for all classes)  Schedule 3  Days to 6 Months \$1,000, Days to 6 Months \$500, Days to 6 Months \$500, Days to 6 Months \$500,					

[a-i]. LIFE (continued)					
[Voluntary Life					
Voluntary Employee Life		☐ Yes			
If yes, do you want to sel		☐ Yes			
Flat amount—indicate level: \$  Minimum amount \$	1				
☐ Maximum benefit \$					
Voluntary Dependent Li (Only available if Employe	<b>ife</b> □ No ee Voluntary Life is chosen)	☐ Yes			
Dependent Child Volunt	tary Amount   \$5,00	0 🗆 \$10,000			
[Rate Guarantee □ 2 Yea [Age Reduction (Refer to you Basic and Voluntary Age I [Portability of coverage (Applic	ur proposal)           Schedule Reduction schedules must m	natch.		Schedule 3] nless mandated by state)]]	
[a-i]. VISION PLANS (all g	group sizes)	·		·	
Plan name (as shown on your	proposal)				
[a-i]. SHORT TERM DISA	ABILITY (group sizes	<b>2-9)</b> . Attach addi	tional signed ar	nd dated sheets (reorder GN-52336), if necessary.	
	Name of Class 1			Name of Class 2	-
Funding type	☐ Contributory ☐ Non-	-contributory		☐ Contributory ☐ Non-contributory	
Benefit schedule (select one)	☐ 60% ☐ Flat amount			□ 60% □ Flat amount \$	
Weekly benefit minimum	\$25.00			\$25.00	
Weekly benefit maximum	\$			\$	
Earnings definition	■ Base Salary			■ Base Salary	
Duration weeks	□ 13 □ 26				
Elimination period (accident/					
sickness)	□ 1/8 □ 8/8 □ 15/1	5 🗆 30/30		□ 1/8 □ 8/8 □ 15/15 □ 30/30	
Pre-existing limitation	<b>■</b> 3/12			<b>■</b> 3/12	
Waiting period: current employees	☐ Eligible on date of emp☐ Eligible after active em	ployment ployment for	_ days	☐ Eligible on date of employment ☐ Eligible after active employment for	days
Waiting period: rehired/new employees	☐ Eligible on date of emp☐ Eligible after active em	ployment ployment for	_ days	☐ Eligible on date of employment ☐ Eligible after active employment for	days
Rate guarantee	■ 2 Years			■ 2 Years	
[a-i]. LONG TERM DISA	BILITY (group sizes 2	<b>2-9)</b> . Attach additio	onal signed and	dated sheets (reorder GN-52336), if necessary.	
	Name of Class 1			Name of Class 2	
Funding type	☐ Contributory ☐ Non-	-contributory		☐ Contributory ☐ Non-contributory	
Benefit schedule (select one)	<b>■</b> 60%			<b>6</b> 0%	
Monthly benefit minimum	■ Greater of \$100 or 10°	% of monthly inco	me loss	■ Greater of \$100 or 10% of monthly inc	ome loss
Monthly benefit maximum	\$	-		\$	
Duration	☐ 5 Years ☐ SSNRA			☐ 5 Years ☐ SSNRA	
Elimination period	Days: □ 90 □ 180			Days: □ 90 □ 180	
Definition of disability	Year own occupation: ■ 2	2		Year own occupation: ■ 2	
Pre-existing limitation	■ 12/24			■ 12/24	
Mental health and substance abuse limitation	■ 24-month outpatient			■ 24-month outpatient	
Waiting period: current employees	☐ Eligible on date of emp☐ Eligible after active em		days	☐ Eligible on date of employment☐ Eligible after active employment for	days
Waiting period: rehired/new employees	☐ Eligible on date of emp☐ Eligible after active em	loyment	days	☐ Eligible on date of employment ☐ Eligible after active employment for	days
Rate guarantee	■ 2 Years	, ,	J -	■ 2 Years	
Survivor income benefit	■ 3 month gross lump su	ım		■ 3 month gross lump sum	

[a-i]. SHORT TERM DISABILITY	(group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336), if necessary.
Name of Class 1	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	□ 50% □ 60% □ 66.67% □ Other □ Flat amount \$
Weekly benefit minimum	\$25.00
Weekly benefit maximum	\$
Earnings definition	■ Base Salary
Duration weeks	□ 13 □ 26 □ 52 □ Other
Elimination period (Accident/Sickness)	□ 1/8 □ 8/8 □ 15/15 □ 30/30 □ Other
Pre-existing limitation	□ None □ 3/12 □ 6/12 □ Other
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Rate guarantee	□ 1 Year □ 2 Years □ Other
Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	□ 50% □ 60% □ 66.67% □ Other □ Flat amount \$
Weekly benefit minimum	\$25.00
Weekly benefit maximum	\$
Earnings definition	■ Base Salary
Duration weeks	□ 13 □ 26 □ 52 □ Other
Elimination period (Accident/Sickness)	□ 1/8 □ 8/8 □ 15/15 □ 30/30 □ Other
Pre-existing limitation	□ None □ 3/12 □ 6/12 □ Other
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Rate guarantee	□ 1 Year □ 2 Years □ Other
a-il. LONG TERM DISABILITY (	group sizes 10+) Attach additional signed and dated sheets (reorder GN-52336) if necessary.
Name of Class 1	
Funding type	□ Contributory □ Non-contributory □ Voluntary
Benefit schedule (select one)	□ 50% □ 60% □ 66.67% □ Other
Monthly benefit minimum	■ Greater of \$100 or 10% of Monthly Income Loss
Monthly benefit maximum	\$
Earnings definition	■ Base Salary
Duration	☐ 2 Years ☐ 5 Years ☐ SSNRA ☐ Other
Elimination period	Days: □ 30 □ 60 □ 90 □ 180 □ Other
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other
Pre-existing limitation	□ 3/3/12 □ 6/6/12 □ 12/12/24 □ 3/6/12 □ 6/6/24 □ Other
Mental health and substance abuse limitation	□ 24-month outpatient □ 12-month outpatient □ Other
Waiting period: current employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Waiting period: rehired/new employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Rate guarantee	☐ 1 Year ☐ 2 Years ☐ Other

AR-71012-EA-SB 4/2012 7 Reorder# AR-52248-SB [4/2012]

## [a-i]. LONG TERM DISABILITY (group sizes 10+) (continued)

Name of Class 2	
Funding type	☐ Contributory ☐ Non-contributory ☐ Voluntary
Benefit schedule (select one)	□ 50% □ 60% □ 66.67% □ Other
Monthly benefit minimum	■ Greater of \$100 or 10% of Monthly Income Loss
Monthly benefit maximum	\$
Earnings definition	■ Base Salary
Duration	□ 2 Years □ 5 Years □ SSNRA □ Other
Elimination period	Days: □ 30 □ 60 □ 90 □ 180 □ Other
Definition of disability	Year own occupation: ☐ 2 ☐ 3 ☐ to age 65 ☐ Other
Pre-existing limitation	□ 3/3/12 □ 6/6/12 □ 12/12/24 □ 3/6/12 □ 6/6/24 □ Other
Mental health and substance abuse limitation	☐ 24-month outpatient ☐ 12-month outpatient ☐ Other
Waiting period: Current employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Waiting period: Rehired/New employees	☐ Eligible on date of employment ☐ Eligible after active employment for days
Rate Guarantee	☐ 1 Year ☐ 2 Years ☐ Other
<b>Additional benefits</b> : Please refer to your progn-52336), if necessary.	roposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder
Cost of living adjustment (3%)	☐ No ☐ Yes If Yes, ■ lesser of 3% or 1/2 CPI, select number of adjustments ☐ 5 ☐ 10
Activities of daily living	□ No □ Yes If Yes, select additional maximum amount □ 10% □ 20% □ 30% □ 40%
Business income protection	□ No □ Yes If Yes, <b>■</b> 25% to \$5,000
Special conditions limitiation	□ No □ Yes If Yes, ■ 24 months
Survivor income benefit	☐ 3-month gross lump sum ☐ 6-month gross lump sum
[a-i]. WORKPLACE VOLUNTARY I	BENEFITS (all group sizes)  ☐ Yes] [Plan design] [☐ Benefits are provided in conjunction with an HSA plan]
[=	[ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
[Benefit period (select all that apply)] [Elimination period (select all that apply)]	[□ [1-24] Months] [□ [1-24] Months] [□ [1-3] Years] [□ [1-3] Years] [□ [0-730] / [0-730]] [□ [0-730] / [0-730]] [□ [0-730] / [0-730]] [□ [0-730] / [0-730]] [□ [0-730] / [0-730]] [□ [0-730] / [0-730]] [□ [0-730] / [0-730]]
	<b>able</b> ] [□ Loss of work] [□ 24-hour coverage] [□ Takeover]
	[ Mental, nervous, alcohol and drug abuse] [ Portability]
	[☐ Sickness elimination period waiver (available only if 7- or 14-day elimination period is selected for sickness)]
Optional Benefits - Employee Select	
' '	Lable   [ CODINA Deficitly
[ Disability Income Advantage] [Base Benefit period (select all that apple	y)] [ [ [1-24] Months]
[Elimination period (select all that apply)	$[\Box [0-730] / [0-730]]  [\Box [0-730] / [0-730]]  [\Box [0-730] / [0-730]]  [\Box [0-730] / [0-730]]$
	$[\Box [0-730] / [0-730]] \ [\Box [0-730] / [0-730]] \ [\Box [0-730] / [0-730]] \ [\Box [0-730] / [0-730]]$
[Optional Riders]	[□ [0-730] / [0-730]]  [□ 24-hour coverage] [□ Hospital confinement] [□ Takeover]  [□ COBRA] [□ Limited mental health/Emotional disease  (only available with EP 0/14, 14/14, or 30/30)]
[ Income Protector (Non-Occ)]	
[Elimination period (select all that apply)	] [ [0-730] / [0-730]] [ [0-730] / [0-730]] [ [0-730] / [0-730]] [ [0-730] / [0-730]] [ [0-730] / [0-730]] [ [0-730] / [0-730]] [ [0-730] / [0-730]] [ [0-730] / [0-730]] [ [0-730] / [0-730]]
[Benefit period (select all that apply)] [Optional Riders]	[ [0-730] / [0-730]] [ [1-90] Days] [ [1-24] Months] [ [1-2] Years] [ [1-2] Years] [ Emergency Accident] [ Outpatient Sickness] [ Hospital Indemnity]

### [a-i]. WORKPLACE VOLUNTARY BENEFITS (continued)

_									
	[ACCIDENT] [☐ Group] [☐ Trust] [☐ ☐ Benefits will be offered in conjunction with		<b>n]</b> [□ Level 1] [□ Level 2] plan]	[□ Level 3] [□ Lev	el 4]				
	with all plans.)	ion] [[ ity (elimination period)] [[ [[	[\$1-1,000]	)0] [Year(s)]] [□ [1-45] [Day	v(s)] [Month(s)] [Year(s)]				
	[  On-the-job coverage]								
	[CRITICAL ILLNESS] [□ No □ Yes]		nefits are provided in conju nefits will be offered in con						
	[Coverage choices]	[□ Vascular]	[□ Cancer] [□ Othe	er critical illnesses [50 or]	100% of face amount]				
	[Optional Benefits - Employer Selectable] [☐ Benefit recurrence] [☐ Loss of work] [☐ Takeover]								
	[Optional Benefits - Employee Selectable] [ Health screening benefit \$] [ Automatic benefit increase]]								
	[CRITICAL LIFE] [□ No □ Yes]	[Plan design] [□ [1-	45] [Day(s)][Month(s)][Year 45] [Day(s)][Month(s)][Year	r(s)]] [□ [1-45] [Day(s) r(s)]] [□ [1-45] [Day(s)	)][Month(s)][Year(s)]] )][Month(s)][Year(s)]]				
	[Optional Benefits - Employer Selectable	e] [□ Waiver of premium [□ Additional benefit i	Loss of work ncrease    Accelerated I nd loss of sight dismemberr	] [□ Takeove iving benefit - critical illne	er]				
	[CANCER] [□ Cancer Expense] [□ Group Lump Sum Cancer]  [□ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]  [Optional Riders - Cancer Expense] [□ Hospital indemnity] [□ Lump sum first diagnosis]  [Optional Benefits - Group Lump Sum Cancer Employer selectable] [□ Benefit recurrence] [□ Loss of work] [□ Takeover benefit]  [Optional Benefits - Group Lump Sum Cancer Employee selectable] [□ Health Screening \$]  [□ Automatic benefit increase]								
	[WHOLE LIFE] [☐ Whole Life 65] [☐ Waiver of premium] [☐ Employee Term to A		[□ Whole I ss of work] [□ Automa	Life 99] atic benefit increase] [[	□ Family Term]				
	[HEALTH CARE PLUS] [Hospital Confinem ☐ Benefits will be offered in conjunction with [Optional Riders] ☐ Hospital Indem								
Γ	[SUPPLEMENTAL HEALTH] [☐ No☐ Yes]	[□ Benefits will be offere	ed in conjunction with an If	RS-qualified pre-tax plan]					
L	[Base plan]	[□ Plan A]	[□ Plan B]	[□ Plan C]	[□ Plan D]				
		[\$100/day] [\$250/day]	[\$200/day] [\$500/day]	[\$300/day] [\$500/day (days 1-2)] [\$750/day (days 3-4)]	[\$500/day] [\$500/day (days 1-2)] [\$1,000/day (days 3-4)]				
	<u> </u>	.] [\$50/day (ER)] [\$40/day (urgent care)] [\$100/day]	[\$100/day (ER)] [\$80/day (urgent care)] [\$200/day]	[\$150/day (ER)] [\$120/day (urgent care)] [\$600/day]	[\$250/day (ER)] [\$200/day (urgent care)] [\$1,000/day]				
	[ Surgical Schedule]	[\$500]	[\$1,000]	[\$1,000]	[\$2,000]				
	[ Diagnostic, laboratory and x-ray]	[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$50/test (hospital)] [\$40/test (doctor's office or clinic)]	[\$75/test (hospital)] [\$60/test (doctor's office or clinic)]				
		[\$25]	[\$50]	[\$75]	[\$100]				
	[ Wellness]	[\$50]	[\$50]	[\$100]	[\$150]				
	[If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.]								

### [1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4)

resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

### [1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility,

underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

### [1-10]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. Neither you nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this EGA, we will decline to enroll you in an insurance product or to give you insurance benefits.

# Do NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE. Dated on: \_\_\_\_\_\_ (month, date, year) at \_\_\_\_\_\_\_ (city and state) By: \_\_\_\_\_\_ (Employer printed name) (Employer signature) (Title) For Workplace Voluntary Benefits - only necessary for non-employer groups. By: \_\_\_\_\_\_ (Plan sponsor printed name) (Plan sponsor signature) (Title)

AR-71012-EA-SB 4/2012 10 Reorder# AR-52248-SB [4/2012]

### [1-10], AGENT/BROKER/PRODUCER INFORMATION

1. Agency of Record (for commissions and corre	espondence)	2. Agent/Agency of I	Record (f	or split	commissions)	
Name (print or type)	Name (print or type)					
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number					
Commission split □ No □ Yes If yes, percentage: (total sho	Commission split  No Yes If yes, percentage: (total should equal 100%)					
1. Writing Agent/Broker/Producer		2. Writing Agent/Bro	ker/Prod	ucer		
Name (print or type)		Name (print or type)				
Social Security Number/Humana Agent Number		Social Security Number/Humana Agent Number				
Commission split □ No □ Yes If yes, percentage: (total sho	uld equal 100%)	Commission split				
ieneral Agency (Complete only if agency involv	ed in sale)					
General agency information pertains to:   Agency	y of Record 🔲 🗎	Writing Agent				
Name (print or type)		Tax ID/Humana Agent N	Number			
Address		City		State	ZIP code	

AR-71012-EA-SB 4/2012 11 Reorder# AR-52248-SB [4/2012]

### Group Employee and Individual Application and Enrollment Form - [[2-99] Employees] [Arkansas]

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee and Individual Application and Enrollment Form as "Humana". To elect primary care physician or dentist, please complete reorder AR-51340-PP.

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [HumanaDental Insurance Company,] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

Please print clearly and fill in each applicable circle.  Proposed effective date:/							/			
Employer / Group n	ame				Emp	loyer / Group	city		St	ate
Qualifying Ever  [O New business  [O New hire / New	s enrollment] ewly eligible]	Date of Qualif  Open Enro Rehire / R	ollment ever	nt] [		ndent birth o al status cha			overage]	]
<b>Enrollment Inf</b>	formation									
Relationship	Last name, Fir	st name MI	Height (ft / in)	Weight (lbs)	Gender	Full-time student?	Date of birth		led? If yes, I within the	indicate reason field below.
Employee / Individual	·		1		O F O M	N/A	//	O N O Y	Reason: SSN: N/A (co	mplete in Employee al Information section.
Spouse / Domestic Partner			1		O F O M	N/A	//	O N O Y	Reason: SSN:	
Child / Dependent			1		O F O M	O N O Y	//	O N O Y	Reason: SSN:	
Child / Dependent			1		O F O M	O N O Y	//	O N O Y	Reason: SSN:	
Child / Dependent			1		O F O M	O N O Y	//	O N O Y	Reason: SSN:	
Other (specify):			1		O F O M	O N O Y	//	O N	Reason: SSN:	
[If yes, please ind	1-12] months have licate whether this a	answer applies	to you (em	ployee / ir	ndividual	or your spo	ouse] [O Employee /	Individu	ıal] [O Spoi	
	ividual Informatio		ırs worked		ek:]	[Date of	full time hire: _	_/		
SSN		5	Street address	;					А	.PT / Suite / Box
City				State	ZIP c	ode	Phon	e # (	)	
Language: O Engl	lish 🔾 Spanish 🔾 Oth	er		E-mail	address			Occupa	ation	
Employment status	(check one) • A	Employment status (check one) • Active • Retiree • COBRA Annual salary \$								
								Annua	l salary \$	
Prior / Existing	g Coverage: IMP					ge until you	receive written no			
Medical	from	n Humana of y	our accepta	ance for co	overage.					
Medical [1-3]. [Prior medical	from	the past [1-18	our accepta ] months (ir	nce for condividual of	overage.		age)? • N • Y]	otificatio	on	
Medical [1-3]. [Prior medical	from	the past [1-18 licy #] [Pri	our accepta  ] months (ir ior coverace  Employee / In	ndividual on dividual on dividual on	or other o	group covera	age)? • N • Y]	etification Effective	date / _	/]
Medical [1-3]. [Prior medical insura	cal coverage during	the past [1-18 licy #] [Pri	our accepta ] months (ir ior coverage Employee / In Employee / In	ndividual of the dividual on dividual an	overage.  or other g  ly] [• Em  d child(ren	group covera ployee / Indivi n)] [ <b>O</b> Family]	age)? O N O Y] idual and spouse]	etification	date / _	/]
Medical [1-3]. [Prior medical insura	cal coverage during ance carrier name [Po	the past [1-18 licy #] [Pri	our accepta ] months (ir ior coverage Employee / In Employee / In	ndividual of the desired of the desi	or other of the coverage.  Ity] [O Em d child(ren	group covera ployee / Indivi n)] [ <b>O</b> Family]	age)? O N O Y] idual and spouse]  I or other group co	Effective Term da	date / _ te / )?	/] Y]
Medical  [1-3]. [Prior medical insura  [1-3]. [Other med	cal coverage during ance carrier name [Po	the past [1-18 licy #] [Pri [O [O tect at the same licy #] [Ot [O tect at the same licy #] [O tect at the same licy #] [Ot [O tect at the same licy #] [Ot [O tect at the same licy #] [O tect at	months (ir ior coverage Employee / In Employee / In e time as thi her covera Employee / In	ndividual of ge type:] dividual on adividual an ais Humana uge type:] dividual on ais Humana	overage.  or other good to be a coverage of the coverage of th	group covera ployee / Indivi n)] [O Family] e (individua	age)? O N O Y] idual and spouse] I or other group co	Effective Effective	date / _ te / )?	/] Y] /]
Medical  [1-3]. [Prior medical insura  [1-3]. [Other med  [Other medical insura	cal coverage during ance carrier name [Po	the past [1-18 licy #] [Pri [O [O tect at the same licy #] [Ot [O tect at the same licy #] [O tect at the same licy #] [Ot [O tect at the same licy #] [Ot [O tect at the same licy #] [O tect at	months (ir ior coverage Employee / In Employee / In e time as thi her covera Employee / In	ndividual of ge type:] dividual on adividual an ais Humana uge type:] dividual on ais Humana	overage.  or other good to be a coverage of the coverage of th	group covera ployee / Indivi n)] [• Family] e (individua ployee / Indivi	age)? O N O Y] idual and spouse] I or other group co	Effective Effective	date / _  te /  )? • N • Y  date / _	/] Y] /]
Medical  [1-3]. [Prior medical insuration  [1-3]. [Other med  [Other medical insuration  [1-3]. [Medicare]	cal coverage during ance carrier name [Po	the past [1-18 licy #] [Pri [O licy #] [Ot licy #]	months (ir for coverage Employee / In Employee / In ther covera Employee / In Employee / In	ndividual of ge type:] dividual on adividual an ais Humana uge type:] dividual on ais Humana	overage.  or other coverage  coverage  coverage  ly] [O Em  coverage  coverage  coverage	ployee / Indivinity [	age)? O N O Y] idual and spouse] I or other group co	Effective Term da Effective Term da	date/_ te/  or date/_ te/ te/	/] Y] /]

	Last name:		First name:	
Dental				
1-2]. [Prior dental coverage during the	e past [1-12] months (in	dividual or other group co	overage)? 🔾 N 🤇	<b>)</b> Y]
1-2]. [Prior orthodontia coverage in t	he past [1-12] months?	ONOY]		
Prior dental insurance carrier name]	Pol	icy #	[P	rior coverage type:]
	Eff	ective date / /	]	[Employee / Individual only] [Employee / Individual and spouse]
Prior carrier phone # ( )]	Ter	m date / /	1 0	[Employee / Individual and child(ren) [Family]
Coverage Options				
Medical	Group #:	Benefit #:	Class/Div	r:
	dual only] [ <b>O</b> Employee / Indual and child(ren)] [ <b>O</b> Fam	dividual and spouse] nily] [• No Coverage (comple	ete waiver)]	[Plan name:]
Health Savings Account	Group #:	Benefit #:	Class/Div	r:
ISAs on Humana.com. Select the Quict Do you elect the Health Savings Account ONOY (If no, complete waiver.)]  Dental  Coverage type:][O Employee / Individ [O Employee / Individ [O Employee / Individ [O Family] [O No Coverage (comp	nt? [Beneficiary for this information on file we group #: [Jual only] [Jual and spouse] [Jual and child(ren)]	account will be the employ	/ee / individual's	e the account is established.]
	Group #:	Benefit #:	Class/Div	<i>/</i> :
Basic dependent life O N O Y (If I	<u> </u>			de you with this information, if needed)]
•	Group #:  [Amount (min [\$1-ui	Benefit #:	Class/Div	
	unt (min \$1-unlimited)	[Voluntary child(ren) lif ○ N ○ Y]	e coverage?	
	Group #:	Benefit #:	Class/Div	
Coverage type:][O Employee / Individ [O Employee / Individ [O Employee / Individ [O Family] [O No Coverage (comple	ual and spouse] ual and child(ren)]			[Plan name:]
hort Term Disability	Group #:	Benefit #:	Cla	ss: Div:
	If no, complete waiver.)]		cent/amount	]
ong Term Disability	Group #:	Benefit #:	Cla	ss: Div:

[Long Term Disability O N O Y (If no, complete waiver.)]

[Buy-up percent/amount \_

	Last name:		F	irst name:	
Workplace Voluntary Be	enefits: Optional riders a	vailability based on e	mployer / group	election.	
Accident	Group #:	Benefit #		Class:	Div:
• Accident] [ • N • Y]		[Benefit Le	evel:] [ <b>O</b> 1-6] [(	O [6-1 O [6-1 O	1-6] [O 1-6] [O 1-6]
Coverage type:] [O Employ	ee / Individual only] [O Em	ployee / Individual and sp	oouse] [O Empl	oyee / Individual and c	hild(ren)] [O Family]
[ <b>O</b> \$1-50,000][per da [ <b>O</b> \$1-50,000][per da	e Care Unit Benefits Rider] y] [per month] [per year]		racture and Dislo	ocation Benefits Ride 0,000]	er]
O Optional Accident Total Disab	ility Benefits Rider: <b>Eliminatio</b>				-
	[Eliminatio	n Benefit:][O \$1-50,0	00] [ \$1-50,000	r] [O 1-120] [Month] 0] [O \$1-50,000] [O 0] [O \$1-50,000]	
Accident - 2012	Group #:	Benefit #		Class:	Div:
[O Accident] [O N O Y]					1-6] [O 1-6] [O 1-6]
Coverage type:] [O Employ	ee / Individual only] [O Em	ployee / Individual and sp	ouse] [O Empl	oyee / Individual and c	hild(ren)] [O Family]
	000][per day] [per month]   000][per day] [per month]				
Disability Income Plus	Group #:	Benefit #	:	Class:	Div:
O Disability Income Covering [Base Benefit Period:]  [Base Elimination Perio	Accident and Sickness] [  O 1-120][Month][Day  O 1-120][Month][Day  d:] O 0-500][/ 0-500]][O  O 0-500][/ 0-500]][O  O 0-500][/ 0-500]]	/s][Year][ <b>O</b> 1-120][Da /s][Year][ <b>O</b> 1-120][Mo <b>O</b> 0-500][/ 0-500]][ <b>O</b>	onth][Days][Year 0-500][/ 0-500]	[O 0-500][/ 0-500]	\$]
O Disability Income Covering [Base Benefit Period:]  [Base Elimination Perio	Accident and Sickness with  [O 1-120][Month][Day  [O 1-120][Month][Day  d:][O 0-500][/ 0-500]][C  [O 0-500][/ 0-500]][C	/s][Year][ <b>O</b> 1-120][Da /s][Year][ <b>O</b> 1-120][Mo <b>O</b> 0-500][/ 0-500]][ <b>O</b>	ys][Year][ <b>〇</b> 1-1 onth][Days][Year 0-500][/ 0-500]	[20] [Month][Days][\ 	]]
Optional Disability Incon		J Benefit] [ <b>3</b> \$1-2,000] [	O \$1-2,000] [O	\$1-2,000] [ \$1-2,0	00] [ \$1-2,000] [ \$1-2,000
	.,	O COBRA Rider]		A Monthly Benefit \$]	
Disability Income Advanta		Benefit #	:	Class:	Div:
Disability Income Advantage [Base Benefit Period:]  [Base Elimination Perio	ge] [	/s][Year][O 1-120][Mo O 0-500][/ 0-500]][O	onth][Days][Year 0-500][/ 0-500]	·] ][ <b>○</b> 0-500][/ 0-500]	\$]
Optional Riders:] [ O Hospital Cor	finement] [O COBRA Rider]		[COBR/	A Monthly Benefit \$]	
Whole Life [/ AD&D]  • Whole Life] [/ AD&D]	Group #:  O Y]  [O Whole Life 99	Benefit #	: O Whole Life 6	Class: [Employee / Indi	Div: vidual Benefit \$]
O AD&D Rider] [O Automatic		1   [ • Whole Life 50]	1 WHOIC LIFE	23   Embloyee / Illul	aaar benene #]
Automatic Benefit Increase Ri  [ \$1-120 /] [Days][Week  [ \$1-120 /] [Days][Week	der] [O Em ][Month] [Year] Em \$]	nployee / Individual Term ployee / Individual Benefi	it	\$] \$]	ild(ren) Benefit
Whole Life Spouse [/ AD&	•	Benefit #		Class:	Div:
Stand Alone Spouse] [/ AD&D]			ole Life 90] [	O Whole Life 65]	[Spouse Benefit \$]
[O AD&D Rider]	[ Family Term Rider (Ch Child(ren) Benefit Am			Automatic	Premium Loan Option]

	Last nam	e:	Fire	st name:	
Whole Life Child(ren) [/ A	AD&D] Group #:	Ben	efit #:	Class:	Div:
(O Whole Life Child(ren)) [//	AD&D] [ <b>O</b> N <b>O</b> Y]				
[Child(ren) listed here mu	st also be includ	led as dependents	under the Enrollment Inf	ormation section of	of this application.]
O N O Y Coverage on Ch	nild 1 Child 1 Na	me			Child 1 Benefit \$]
ONOY Coverage on Ch	hild 2 Child 2 Na	me			Child 2 Benefit \$]
ONOY Coverage on Ch	hild 3 Child 3 Na	me			Child 3 Benefit \$]
Level Term Life	Group #:	Ben	efit #:	Class:	Div:
O Level Term Life] [/ AD&D] [O	NOY]	[Coverage type:]	[O Employee / Individual only] [O Spouse] [O Child(ren)]		Year Term] [ 20-Year Term] [ Automatic Benefit Increase
[Employee / Individual Benefit \$]		[Spouse Benefit \$]		[Child(ren) Benefit \$]	
a history of heart attack, [If yes, please indicate wheth [O You (Employee / Individual Term to 95]	er this applies to yo	ou (Employee / Individ Dependent] [Name_			Div:
[ <b>O</b> Term to 95] [ <b>O</b> N <b>O</b> Y]		[Coverage type:] [	• Employee / Individual only]	[O Spouse] [O Chi	ldren]
[Employee / Individual Benefit \$]		[Stand alone Spouse \$]	Benefit	[Stand alone Child(re \$]	n) Benefit
Critical Illness	Group #:	Ben	efit #:	Class:	Div:
		[Coverage type:]	O Employee / Individual o	nlul [O Employee	(Individual and enqueal
[O Critical Illness]		[coverage type.]	[O Employee / Individual a		
O Critical Illness and Cance	er] [ONOY]		C Employee / Individual a	nd child(ren)] (O F	amily]
O Critical Illness and Cance	er] [O N O Y] omatic Benefit Increa	se] [ <b>O</b> Health Screeni	Employee / Individual a	nd child(ren)] [O F	amily] I Benefit \$]
O Critical Illness and Cance [Optional Benefits:] O Auto [Have you or any depended]	r] [O N O Y]  omatic Benefit Increa  ent had a parent	ise] [O Health Screening, brother, or sister	Employee / Individual a  ng] [ Return on Premium]  with a history of heart a	nd child(ren)] ( F  [Employee / Individuation of the content of th	amily]  I Benefit \$]  e, stroke, or cancer
O Critical Illness and Cance	omatic Benefit Increa ent had a parent 100]? O N O Y	ise] [O Health Screening the brother, or sister [If yes, please indicates]	mg] [O Return on Premium]  with a history of heart a te whether this applies to you	nd child(ren)] ( F  [Employee / Individuation of the content of th	amily]  I Benefit \$]  e, stroke, or cancer
O Critical Illness and Cance [Optional Benefits:] O Auto [Have you or any dependediagnosis prior to age [1-	omatic Benefit Increa ent had a parent 100]? O N O Y] ee / Individual)] [O	Ise] [O Health Screening, brother, or sister [If yes, please indicates Spouse] [O Depended]	mg] [O Return on Premium]  with a history of heart a te whether this applies to you	nd child(ren)] ( F  [Employee / Individuation of the content of th	amily]  I Benefit \$]  e, stroke, or cancer
O Critical Illness and Cance [Optional Benefits:] O Auto [Have you or any depending diagnosis prior to age [1-dependent. O You (Employe	omatic Benefit Increa ent had a parent 100]? O N O Y] ee / Individual)] [O	Ise] [ Health Screening the prother, or sister [If yes, please indicated Spouse] [ Dependent Bender 1]	Demployee / Individual and Inglication    mg] Description    mith a history of heart and te whether this applies to you dent] [Name	Imd child(ren)] ( For a	amily]  I Benefit \$]  e, stroke, or cancer  ual), your spouse or a  Div:
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer	ent had a parent er / Individual)] [O Group #: [O N O Y] ent had a parent er this applies to yo	Ise] [ Health Screening, the brother, or sister [If yes, please indicated Spouse] [ Dependent Properties of the brother, or sister ou (Employee / Individual properties of the brother, or sister ou (Employee / Individual properties of the brother, or sister ou (Employee / Individual properties of the brother, or sister ou (Employee / Individual properties of the brother, or sister ou (Employee / Individual properties of the brother, or sister out (Employee / Individual properties of the brother, or sister out (Employee / Individual properties of the brother, or sister out (Employee / Individual properties of the brother, or sister out (Employee / Individual properties of the brother)	Employee / Individual a  mg] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name  efit #:  [ Employee / Individual o  Employee / Individual a  with a history of cancer	rnd child(ren)] ( Figure 1	e, stroke, or cancer ual), your spouse or a  Div:  Individual and spouse] amily]
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer [O Group Lump Sum Cancer] [Have you or any depend [If yes, please indicate wheth	omatic Benefit Increa ent had a parent 100]? O N O Y] ee / Individual)] [O Group #: [O N O Y] ent had a parent er this applies to yo al)] [O Spouse] [O	Health Screening  t, brother, or sister  [If yes, please indicates  Spouse] [O Dependent  Bendent  [Coverage type:]  t, brother, or sister  bu (Employee / Individed Dependent) [Name_	Employee / Individual a  mg] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name  efit #:  [ Employee / Individual o  Employee / Individual a  with a history of cancer	rnd child(ren)] ( Figure 1	e, stroke, or cancer ual), your spouse or a  Div:  Individual and spouse] amily]
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer] [O Group Lump Sum Cancer] [Have you or any depend [If yes, please indicate wheth [O You (Employee / Individual [Rider:] [O Automatic Benefits:]	omatic Benefit Increa ent had a parent 100]? O N O Y] ee / Individual)] [O Group #: [O N O Y] ent had a parent er this applies to yo al)] [O Spouse] [O efit Increase] [O He	Health Screenings, brother, or sister [If yes, please indicated Spouse] Dependence [Coverage type:]  t, brother, or sister pure (Employee / Individual Compondent) [Name_ealth Screenings]	Employee / Individual a  ng] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name_ efit #:  [ Employee / Individual o	nd child(ren)] ( Figure 1	amily]  I Benefit \$]  e, stroke, or cancer  ual), your spouse or a  Div:  Individual and spouse]  amily]  age [1-100] ? • N • Y]
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend- diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer] [O Group Lump Sum Cancer] [Have you or any depend- [If yes, please indicate wheth [O You (Employee / Individual	omatic Benefit Increa ent had a parent 100]? O N O Y] ee / Individual)] [O Group #: [O N O Y] ent had a parent er this applies to yo al)] [O Spouse] [O	Ise] [O Health Screening, brother, or sister [If yes, please indicated Spouse] [O Dependent Bender   Coverage type:]  It, brother, or sister ou (Employee / Individe Dependent] [Name_ealth Screenings]	mg] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name  efit #:  [ Employee / Individual o	Image child(ren)] ( Figure 1	amily]  I Benefit \$]  e, stroke, or cancer  ual), your spouse or a  Div:  / Individual and spouse]  amily]  age [1-100] ? O N O Y]
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend- diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer [O Group Lump Sum Cancer] [Have you or any depend- [If yes, please indicate wheth- [O You (Employee / Individual [Rider:] [O Automatic Benefits of the cancer Expense]	ent had a parent er this applies to you ent had a parent er this applies this applies to you ent had a parent er this applies to you ent had a parent er this applies this applies to yo	Health Screenings   Health Screenings   Health Screenings     Health Screenings   Health Screenings     Health Screenings     Health Screenings   Health Screenings     Health Screenings	mg] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name_ efit #:  [ Employee / Individual o	Indichild(ren)] OF  [Employee / Individual  Itack, heart diseas  I (Employee / Individual  Class:  Inly] OEmployee / Indichild(ren)] OF  Idiagnosis prior to Ident.  Class:  Inly] OEmployee / Indichild(ren)] OF  Idiagnosis prior to Ident.	amily]  I Benefit \$]  e, stroke, or cancer  ual), your spouse or a  Div:  Individual and spouse]  amily]  age [1-100] ? O N O Y]  Div:  Individual and spouse]  amily]
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend- diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer [O Group Lump Sum Cancer] [Have you or any depend- [If yes, please indicate wheth- [O You (Employee / Individual [Rider:] [O Automatic Benefit Cancer Expense [O Cancer Expense]	ent had a parent er this applies to you ent had a parent er this applies this applies to you ent had a parent er this applies to you ent had a parent er this applies this applies to yo	Health Screening   Health Scre	Employee / Individual a  mg] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name	Indichild(ren)] OF  [Employee / Individual  Itack, heart diseas  I (Employee / Individual  Class:  Inly] OEmployee / Indichild(ren)] OF  Idiagnosis prior to Ident.  Class:  Inly] OEmployee / Indichild(ren)] OF  Idiagnosis prior to Ident.	amily]  I Benefit \$]  e, stroke, or cancer  ual), your spouse or a  Div:  Individual and spouse]  amily]  age [1-100] ? O N O Y]  Div:  Individual and spouse]  amily]
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer [O Group Lump Sum Cancer]  [Have you or any depend [If yes, please indicate wheth [O You (Employee / Individual [Rider:] [O Automatic Benefit Cancer Expense [O Cancer Expense]  [O Lump Sum Benefit (Equa Supplemental Health	ent had a parent er this applies to yo ent had a parent er this applies	Coverage type:	mg] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name  efit #:  [ Employee / Individual o	Image of the control	amily]  l Benefit \$]  e, stroke, or cancer  ual), your spouse or a    Div:  / Individual and spouse]  amily]  age [1-100] ? O N O Y  / Individual and spouse]  amily]  fit \$]  Div:  / Individual and spouse]
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer [O Group Lump Sum Cancer]  [Have you or any depend [If yes, please indicate wheth [O You (Employee / Individual [Rider:] [O Automatic Benefit Cancer Expense [O Cancer Expense]  [O Lump Sum Benefit (Equal Supplemental Health [O Supplemental Health] [O	ent had a parent er this applies to yo ent had a parent er this applies	See   O   Health Screenings   O   Health Screenings   O   Dependent   Coverage type:	mg] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name_ efit #:  [ Employee / Individual o	Image of the control	amily]  l Benefit \$]  e, stroke, or cancer  ual), your spouse or a    Div:  / Individual and spouse]  amily]  age [1-100] ? O N O Y  / Individual and spouse]  amily]  fit \$]  Div:  / Individual and spouse]
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer [O Group Lump Sum Cancer]  [Have you or any depend [If yes, please indicate wheth [O You (Employee / Individual [Rider:] [O Automatic Benefit (Equal Cancer Expense [O Cancer Expense] [O Lump Sum Benefit (Equal Supplemental Health [O Supplemental Health] [O [Plan type:] [O 1-6] [O 1-6]	ent had a parent er this applies to yo ent had a parent er this applies	Coverage type:	mg] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name_ efit #:  [ Employee / Individual o	Image of the control	Amily]  I Benefit \$]  e, stroke, or cancer  Lial), your spouse or a  Div:  I Individual and spouse]  amily]  age [1-100] ? O N O Y]  Div:  I Individual and spouse]  amily]  fit \$]  Div:  I Individual and spouse]
[O Critical Illness and Cance [Optional Benefits:] [O Auto [Have you or any depend diagnosis prior to age [1- dependent. [O You (Employe Group Lump Sum Cancer [O Group Lump Sum Cancer]  [Have you or any depend [If yes, please indicate wheth [O You (Employee / Individual [Rider:] [O Automatic Benefit Cancer Expense [O Cancer Expense]  [O Lump Sum Benefit (Equal Supplemental Health [O Supplemental Health] [O	ent had a parent er this applies to yo ent had a parent er this applies	Coverage type:	mg] [ Return on Premium]  with a history of heart a te whether this applies to you dent] [Name  efit #:  [ Employee / Individual o	Image of the control	amily]  I Benefit \$]  e, stroke, or cancer  ual), your spouse or a  Div:  Individual and spouse]  amily]  age [1-100] ?  N  Y  Div:  Individual and spouse]  amily]  fit \$]  Div:  Individual and spouse]  amily]

Last name:		First name:		
vidence of Health Status				
nis information should not be submitted more than [ dividuals, including dependents, enrolling or applyin overage.]				it
his section is required to be filled out for [Group Ter ollowing criteria applies:] -3.] [Over Guaranteed Issue Limit: Election of covera which evidence of insurability is required.] -3.] [Opting up to Higher Level of Coverage: election -3.] [Late Entrant: Employee who did not enroll during or date of family status change, or during an an	ge exceeding the guaranto of additional increments ng one of the following eli	eed issue amount (according of coverage with insurance gibility periods: initial eligib	to your po currently in pility date o	force.]
<ul> <li>-7.] [Are you or any dependents currently taking any prescril recurrent condition?</li> </ul>				NOY]
-7.] [In the past [1-12] months, have you missed [1-5] or mo a result of a cold, the flu, [back problems,] strained/spra	ore consecutive days of work d nined/fractured/broken limb or	ue to an injury or illness other that as a result of pregnancy?	nan as O	NOY]
-7.] [Have you or any dependent been diagnosed or received ITP), ]AIDS or an AIDS-related complex?	. ,	` ' '	[Y <b>C</b> <i>V</i>	
-7.] [Within the past [1-5] years, have you or any eligible de counseled, consulted, or treated by a doctor, including s	pendent to be covered been di urgery, for any of the following	iagnosed with diseases or disord g:]	lers related to	',
Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; hemophilia; phlebitis; high blood pressure [(reading higher	O Y [a- enlargement	er or thyroid disease; hepatitis; co cof the lymph nodes?	irrhosis; or	O N
than 140/90)]?  Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?		ll bladder, digestive, intestinal, or	r colon	O N
Stroke; Transient Ischemic Attack (TIA)?	ON Table 1 [a- Rheumatoid on disorders]?	arthritis[; [or] back disorders; or	joint	N C Y C
Emphysema; asthma, or other disease of lungs, or respiratory organs?	O N T Paralysis, or O.	any other physical impairment or	r deformity?	O N O Y
End stage renal disease; disease of kidney?	ON Chronic Fatigon	gue Syndrome/Fibromyalgia?		O N O Y
Kidney stones; bladder?	ON Diseases of t	the eye, ear, nose, or throat?		O N O Y
Male or female organs; or infertility?	O N O Y	or drug habit?		N C
- Cancer, and/or cancerous tumor[; including skin cancer]?	O N J			
7.] [Has any Proposed Insured been advised by a member of hospitalization, or surgery that has not been completed		ave any diagnostic test,	O	NOY]
-7.] [Within the past [1-5] years, has anyone enrolling or ap routine physical/wellness exam, or been seen for any re	ason not previously disclosed?	)		NO Y
-7.] [Are you or any dependent to be covered currently preg [Anticipated delivery date:	nant? If yes, please indicate a	nticipated delivery date below.	0	NOY]

Question # & letter	Person treated (Last name, First name)		
Condition		Treatments received	
Medications prescribed		Current or future treatments or medications	
Date diagnosed / /		Date last seen by a doctor / / ]	

Medical Health History		
	submitted more than 60 days prior to the effective date. [Complete this section g for medical, disability, life, or workplace voluntary benefit coverage.]	ı for individuals,
[1-6.] [Are you or any dependents to be Anticipated delivery date:	pe covered currently pregnant? If yes, please indicate anticipated delivery date below.	ONOY]
	e you missed [1-5] or more consecutive days of work due to an injury or illness other than as a roblems], strained/sprained/fractured/broken limb or as a result of pregnancy?	ONOY]
[1-6.] [Have you or any dependent bed AIDS-related complex?	en diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an	ONOY]
[1-6.] [Are you or any dependents current condition?	rently taking any prescribed medication, or do you periodically take medication for a recurrent	ONOY]
[1-6.] [During the last [1-24] months, or had surgery or hospitalization	have you or any dependents to be covered been diagnosed with, or treated for, any illness or injury n recommended?	ONOY]
[1-6.] [Within the past [1-12] months, [\$1-100,000]?	have you or any dependents to be covered incurred medical expenses in excess of	ONOY]
If selecting life, please comple	te the following questions:	
any of the following: heart attac not been controlled with medica renal/kidney disease, diabetes (ii	bosed Insured been diagnosed, sought treatment, taken medication, or been hospitalized for k/heart surgery/heart disease, blood pressure readings above the normal range which have stroke/transient ischemic attack (TIA), cancer (except basal cell skin cancer), end stage insulin dependent), alcohol and/or drug abuse, emphysema/lung disease, liver disease/disorder/multiple sclerosis, lupus, blood disorder, or epilepsy?	ONOY]
[1-4.] [Had a parent, brother, or sister	with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100]?	ONOY]
	erage ever been diagnosed with or treated for congenital cardiac abnormality or other n's syndrome, cerebral palsy, or cystic fibrosis?	ONOY]
	advised by a member of the medical profession to have any diagnostic test, hospitalization, npleted within the past [1-5] years?	ONOY]
	of the questions above, please provide details below and specify the question nuets (reorder AR-51340-MH), if necessary.]	ımber. Attach
Question #	Person treated (Last name, First name)	
Condition	Treatments received	

Last name:

First name:

Current or future treatments or medications

Date last seen by a doctor \_ \_ / \_ \_ / \_ \_ \_

Medications prescribed

Date diagnosed \_ \_ / \_ \_ / \_ \_ \_

I proclaim that I was not pressure	d or forced by	my employer / g	roup, the writing agent, or Hu	mana into waiving (declining) coverage. If I have
waived any coverage offered to m	ne or my depei	ndents, my signa	ture is evidence of this action.	
I hereby waive coverage for (che	ck all that app	oly):		I decline to apply for group coverage because of:
[Medical for: [Dental for: [Basic Life for: [Vision for: [Short Term Disability for: [Long Term Disability for: [Health Savings Account for:	<ul><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li></ul>	<ul><li>My spouse</li><li>My spouse</li></ul>	<ul> <li>My dependent child(ren)]</li> <li>My dependent child(ren)]</li> <li>My dependent child(ren)]</li> <li>My dependent child(ren)]</li> </ul>	[O Medicare supplement]
Waive Coverage for Workpl		y Benefits:		
[Whole Life for: [Level Term Life for: [Term to 95 for: [Critical Illness for: [Group Lump Sum Cancer for: [Cancer Expense for: [Supplemental Health for: [Accident for: [Disability Income Plus for:	<ul><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li><li>Myself</li></ul>	<ul><li>My spouse</li><li>My spouse</li><li>My spouse</li><li>My spouse</li><li>My spouse</li><li>My spouse</li><li>My spouse</li><li>My spouse</li></ul>	<ul> <li>My dependent child(ren)</li> </ul>	

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group.

First name:

### **Agreement**

### True and complete acknowledgement

[Disability Income Advantage for: Myself]

I understand, agree, and represent:

Waiver (refusal of coverage)

- I have read the Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete
  to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-31] days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to Humana.

Last name:

- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-60] days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-31] days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Group Employee and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny claims or void the contract or coverage within the contestable period, if such misrepresentation materially affected the acceptance of the risk.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization		
<ul> <li>My dependents and I understand and agree:</li> <li>The information obtained by use of this authorizative ligibility for benefits under an existing policy and policy and policy and policy and policy information obtained will not be released by H Bureau, Inc. or other persons or organizations performance and Individual Application and Enrollmen</li> </ul>	plan administration. lumana to any person or organization except to orming health care operations or business or lec	reinsuring companies, the Medical Information
Authorization for Release of Medical Records for the selected life or disability, I are non-medical information and to share any and all such personal and health (including medical, dental, and phand the information may not be protected by federal are	authorize any third party to have information re h information with Humana, its reinsurer or its l narmacy) information is disclosed pursuant to th	egal representatives, and its affiliates. Once
The Group Employee and Individual Application of any contract and be the basis for any policy		y supplemental forms, will make up part
Signature - please sign below if enrolling		
If you decide not to sign this authorization, Hu to the inability to obtain the necessary informa	mana cannot complete your plan enrollm ation.	nent or determine your premium rate due
Employee / Individual or legal representative signature	2:	Date:
Name and relationship of legal representative:		
Spouse signature:(Only if selecting Life cover	age over the guarantee issue amount.)	
Agent / Producer Information		
If applying for workplace voluntary benefits, the	his section to be completed by Agent or I	Producer.
1 Agent / Agency of Pocord:	2. Agent / Agency of R	
Name (print)	Name (print)	
Humana Agent #	Humana Agent #	
Commission split:	Commission split:	
1. Writing Agent / Producer:	2. Writing Agent / Prod	ducer:
Name (print)	Name (print)	
Humana Agent #	Humana Agent #	
Commission split:	Commission split:	
Will the coverage selected replace or change a	ny existing life or disability insurance po	licy(s) and/or annuity(s)? ONOY
As the Writing Agent / Producer, I acknowledge that I Individual Application and Enrollment Form in order to offering or insuring entity, or one of its subsidiaries. Th or other plan literature.	o fully and accurately represent the terms and conese provisions are available to me and the prime	onditions of the plans and services of the
Signed at		
	County	State
Writing Agent's Signature		Date//

First name:

Last name:

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

La	rge Group Er	npl	loye	ee aı	nd	Indi	ivid	lual	A	ppl	ica	itic	n a	anc	l Er	rol	me	ent	Fo	rm	l										
	offering company( ndividual Applica											, as	the	con	iten	t may	rec	quire	, ar	e re	ferr	ed	to	in tl	ne L	arge	Gre	oup	Emp	loyee	<u> </u>
Comp Arkan Insura	ical plans insured o pany,] [Humana Ins nsas, Inc.] [Vision p ance Company].] [[ ance Company.] [Li	urar lans Gro	nce ( s insu up C	Compa ured or ritical	anyj r adr Illne	[or] [ minis ss], [	Com tered Shor	pBer d by t Ter	nefit [Hur m D	s In: man isab	sura aDe oility	ance enta v], [L	Cor I Ins ong	mpa urar Teri	ny]. nce ( m Di	[Der Comp sabili	ital l any, ty] [a	HMC ] [Hu and]	pla uma [W	ns na l orkp	offe Insu olace	red ran e Vo	by i ce ( olun	Ame Com Itary	erica pan ] pla	n De y] [o ans i	enta r] [C nsur	Pro	vider Ben	s of efits	а
Print	clearly and con	nple	etely	/ fill i	n ea	ch a	ppli	icab	le c	ircl	e.																				
Emplo	oyer / Group name	!												1	Em	ploye	r / G	roup	cit	/									] [	State	
	ualifying Event I New business enroll				• Оре	en En	rollm	ient e	vent	:]	[0	<b>)</b> Ma	arital	stat	us cl	nange	] [	O <b>C</b>	thei								]	Offi	ice u	se o	nly
[O]	New hire/Newly elig	ible]		[C	Reh	nire/R	einst	atem	ent]	Qu	alify	/ing	ever	nt d	ate	MM/	DD/\	YYYY	<b>'</b> )			Bei	nefi	t eff	ectiv	∕e da	ate (	MM	/DD/	YYYY	)
[O]	Dependent birth or a	adop	tion]	[0	Los	s of c	overa	age]				/			/				]					/			/				]
En	nployee / Ind	ivi	dua	al inf	orr	nat	ion																								
Last n															Firs	t nam	e													М	_
Social	I security number					,	Date	e of l	oirth	n (M	M/[	DD/\	YYY	()				Α	rea	COC	le		Pho	ne i	num	ber					_
	- [	-							/			/						(				)				-					
Heigh	nt (ft / in)	į	Weig	ght (lb	s)																										
	/																														
Street	address																						ı								_
Apt /	Suite / PO box nur	nber	r I I		<i>C</i> -			Г	-1-	$\sim$ 1	4-1	_		1			د داد	: /	~ F	1.											
City					Ge	nder	0	rem	aie	O I	viai	е		Lan	_	ge of -			) E	nglis	sh C				/ Da	rich					
City														Stat	le	] [	.ip €	ode					COL	lity	/ Pa	11211					
F-mai	il address																														
Linui	ii ddaless																														
Emplo	oyment status 🔾 f	Enllet	tima	emple	0000	/ ind	ividu	ıal O	Ro	tiroc	. 0	CO	RR A	D:	ato (	of full.	time	ο hir	2 /N/	M/D	D/VV	۷V۱		<del> </del>	٦,			, [			
Do yo	ou have a disability y to communicate	tha	t aff	ects yo	our	<b>O</b>		iui <b>3</b>	А	re y <b>)</b> No	ou (	disa <b>O</b> Y	bled es l	or u	unak s, in	ole to dicate	perf e rea	orm	nor	mal	WO	rk a	activ	/ities	' 5?			<i>'</i>			
<b>*</b>	Annual Salary									 	Hou	ırs V	Vork	ced	per	Weel	< 														
\$																															
	Occupation										1												Т								
		Prir	mary	care p	ohys	ician	nam	ne								Pri	mary	y car	e pł	ıysid	cian	ID	#				(		•	atient	
	HMO/POSonly																											0	Yes (	ON C	)
	HMO/POSonly	ОВ	GYN	l Prima	ary c	are p	hysio	cian	nam	ne	(if a	appl	icab	le)		Pri	mary	y car	e pł	nysio	cian	ID	#				(			atient <b>O</b> No	
	THINIO/FUSUIHY																											•	162	J IVC	

First name:

Last name:

D	ependent information	
Ente	er information for each covered dependent, including spouse.	
1	Dependent last name First name	ne MI Gender
•		G Female G Male
	Social security number  Date of birth (MM/DD/Y	
		O Spouse O Child O Other:
	Height (ft / in) Weight (lbs)  Dependent status (if app  If disabled, indicate reason	oplicable): O Full-time student O Disabled
	Not applicable for HumanaAccess HMO	
	Primary care physician name	Primary care physician ID # Current patient?
	HMO/POS only	O Yes O No
	OBGYN Primary care physician name (if applicable)	e) Primary care physician ID # Current patient?
	HMO/POS only	O Yes O No
_	Dependent last name First name	ne MI Gender
2	Peperlacine last name	O Female O Male
	Social security number  Date of birth (MM/DD/Y	
		O Spouse O Child O Other:
	Height (ft / in) Weight (lbs)	
		oplicable): • Full-time student • Disabled ason:
	Not applicable for HumanaAccess HMO	
	Primary care physician name	Primary care physician ID # Current patient?
	HMO/POS only	O Yes O No
	OBGYN Primary care physician name (if applicable)	) Primary care physician ID # Current patient?
	HMO/POS only	O Yes O No
7	Dependent last name First name	ne MI Gender
5		O Female O Male
	Social security number  Date of birth (MM/DD/Y	
		O Spouse O Child O Other:
	Height (ft / in) Weight (lbs)	oplicable): O Full-time student O Disabled
	If disabled, indicate reason	
	Not applicable for HumanaAccess HMO	
	Primary care physician name	Primary care physician ID # Current patient?
	HMO/POS only	O Yes O No
	OBGYN Primary care physician name (if applicable)	Primary care physician ID # Current patient?
	HMO/POS only	○ Yes ○ No
<u></u>	Dependent last name First name	ne MI Gender
4		O Female O Male
	Social security number  Date of birth (MM/DD/Y	
		O Spouse O Child O Other:
	Height (ft / in) Weight (lbs)	Splicable), O Full time student O Disabled
	If disabled, indicate reason	pplicable): • Full-time student • Disabled ason:
	Not applicable for HumanaAccess HMO	
	Primary care physician name	Primary care physician ID # Current patient?
	HMO/POS only	O Yes O No
	OBGYN Primary care physician name (if applicable)	e) Primary care physician ID # Current patient?
	HMO/POS only	O Yes O No

Last name:

First name:

			Last r	name:										Fii	rst na	ame:									
Ise the follow	ving alternate a	ddress foi	r these	depen	dents:	<b>O</b> 1	O	2 C	3 C	4															
treet address	5																								
pt / Suite / P	O box number																								
ity							Sta	te	7	ip co	de				Col	unty									
							514		] [	p co															
Medical									J L																
	oe:][ <b>O</b> Employe	a / Individ	hual onl	v1																					
.overage typ	Employe (C) Sec.][ کا Employe				]				se oi	nly					Do	nefit	#						Cla	iss/Di	iv. #
	[O Employe						Grou	μ μ							De	Пеп	#						Cla	133/10	V #
	[ <b>O</b> Family] [ <b>O</b> Other]																								
Plan name												1	Netw	/ork	nam	ie 🗌									
• Do you or	any covered de	ependent(	s) curre	ntly ha	ave oth	ner m	edic	al c	overa	ge, s	uch a	as a	spou	ıse's	pla	n, an	othe	r Hu	man	a m	edic	al pla	an, o	r	
	O Yes O No	•	list all:	(This	section	n mu	st be	e coi	mplet							•		cal c	laim	s.)]]					
[Medicare I	D or medical carr	ier name:							1	[Me	dicar	e ID	or me	edica	al car	rier n	ame:								
				[6					]											10					
[Starting da	ite (MM/DD/YYY	Y)		(check	age Typ all that a		1			[Sta	rting	date	(MN	1/DD	/YYY 	Y)						e Typ that a			
	′		]		ployee			ıal]				/			/ _				]					ividua	al]
[End date, i	f applicable (MM	I/DD/YYYY)		[O Sp						[End	date	e, it a	applic	able	(MN	1/DD/	YYYY	<u>()</u>			Spou				
				[O Ch	ild(ren)	]						_ /			/				_ ]	O)	Child	(ren)]			
	or any covered																	lan)	in th	е ра	ast [	1-18	] mo	nths	?
	No] [If yes, list	all: (This	section	must	be cor	nplet	ted f	or H	umar				-			claim	s)]]								
[Prior medic	cal carrier name:								,	[Pric	or me	dical	l carri	ier n	ame:										
	. // // // // // // // // // // // // //			[Cover	ago Tur	20			]	[6:	<u> </u>		(2.42	4/00	000					[(0)	orag	e Typ			
[Starting da	ate (MM/DD/YYY	Y)			age Typall that		]			[Sta	rtıng	date	(MV	1/00	/YYY , [	Y)						e Typ that a			
[E   ] ,	/ / _	D 0 0 0 0 0			nployee			ıal]			1.	_	1. 1	1 (1	/ _	DAW								ividua	al]
[End date, if	applicable (MM/D	D/YYYY)	1		ouse]					[End	date	, if ap	plicat	oie (iv	/IIVI/L , [	D/YY	Y Y )					se]			
				[ <b>O</b> Ch	ild(ren)	)]						] / [			′ _				]	O (	Child	(ren)]			
Health 9	Savings Ac	count (	HSA)	Appli	cable	only	with	n Hig	gh De	duct	ible	Heal	lth P	lan s	seled	tion									
	ct the Health Sa						Offic	ce u	se oi	nly															
	O No If no, o	'					Grou			•					Ве	nefit	#						Cla	ss/D	iv#
you may r	ve medical co not be eligibl tax advisor f	e for an	HSA. P																						
,	r to Humana's																								

HSAs on Humana.com. Select the Quick Link for Spending Account information on the member page.

Beneficiary for this account will be the employee / individual 's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Last name:	First name:
Flexible Spending Account (FSA)	
Do you elect the flexible health account?  O Yes O No If no, complete waiver section  Annual amount elected:  \$	Benefit # Class/Div #
Start date (MM/DD/YYYY)  Do you elect the flexible dependent care account?  Yes No If no, complete waiver section  Annual amount elected:  \$	Benefit # Class/Div #
Dental	
Office use only Group # Benefit #	Class/Div #
[Coverage Type] [O Employee / Individual only] [O Employee / Individual and spou	use] [O Employee / Individual and child(ren)]
[O Family] [O Other] Plan name	
[• Within the past [1-12] months, have you or any covered family individual had any dental or a spouse's dental coverage? • Yes • No] [If yes, list all: (This section must be completed [Orthodontia [Starting date	d for Humana to process any dental claims)]] [End date, if applicable
[Current dental carrier name: coverage? (MM/DD/YYYY)	(MM/DD/YYYY)
[Coverage Type (check all that apply)] [O Employee / Individual] [O Spouse] [O Child(ren)]	
[Orthodontia [Starting date coverage? (MM/DD/YYYY)]  [Coverage Type [O Employee / Individual only] [O Employee / Individual and child(ren)] [O Family]	[End date, if applicable (MM/DD/YYYY)] / / / / / / / / / / / / / / / / / / /
[ Employee Primary care dentist name [Dentist ID #	# [Current patient?  O Yes O No]
[ Employee Primary care dentist name] [ Dentist	[Current patient? Yes O No]  Yes O No]  Yes O No]  Yes O No]
Basic Life [/ AD&D]	
Office use only Group # Benefit #	Class/Div #
[Do you elect basic employee / individual life coverage? • Yes • No If no, complete wait	ver section]
[Class (employer / group will provide you with this information if needed)  [Do you elect basic dependent life? • Yes • No If no, complete waiver section]	

		Last name:		First name:		
Voluntary	Life [/ AD&D]					
Office use on	ly Group #	Bene	fit #		Class/Div #	
[Do you elect vo	oluntary employee / ind	lividual life coverage?				
O Yes O No	[If no, complete waiver	r section]]				
[If yes, amount	elected (minimum of [\$	\$1-Unlimited]): \$ ,	.00]			
Voluntary de	pendent life selectio	on (available only if employee / i	ndividual elects v	oluntary life cove	erage):	
[Do you elect vo	oluntary spouse life cov	rerage? • Yes • No If no, comple	ete waiver section]			
[If yes, voluntar	y spouse life coverage	(minimum of [\$1-Unlimited]):	\$ ,	.00]		
[Do you elect vo	oluntary child(ren) life c	coverage? • Yes • No If no, con	iplete waiver section	n]		
Vision						
Office use on	ly Group #	Bene	fit #		Class/Div #	
[Covered individe	ual] [• Employee / [• Family]	Individual only] [	Individual and spous	se] [O Employee	e / Individual an	nd child(ren)]
Plan name						
Short Terr	n Disability					
- [Do you elect sh	nort term disability cove	erage? Office use only				
O Yes O No	If no, complete waiver	section] Group #	Benefit #	#	Class #	Div #
[Buy-up percent	:/amount	]				
Long Term	n Disability					
Do you elect lo	ng term disability cover		D	1	Class II	D: II
O Yes O No	If no, complete waiver	section] Group #	Benefit #	Ŧ	Class #	Div #
Buy-up percent/	/amount	]				
Group Tei	rm Life [/ AD&D]					
Office use on	ly Group#	Benefit#		Class	#	Div#
Coverage requ	ested for (check all that		verage requested		Cost per pay	period
[Employee /	☐ Basic Term Life	(complete only if plan	provides a choice of be	enetit schedules) \$		.00
[Employee / Individual]	O Supplemental Ter					.00
	O Basic AD&D			\$		.00
	O Supplemental AD			\$		.00
[Spouse]	O Basic Term Life	<u></u>		\$		.00
[spouse]	Supplemental Ter	m Life*		\$	,	.00
	O Basic AD&D			\$		.00
	☐ Supplemental AD	&D		\$	,	.00
[Child(ren)]	O Basic Term Life			\$	,	.00
	[O Supplemental Ter	m Life*		\$	,	.00
	O Basic AD&D			\$	,	.00
	O Supplemental AD			\$		.00
*Complete Evic	lence of Insurability for	m if selecting one of these benefit ar	nounts.			

5

AR-72001 4/2012

Last name:	First name:								
Workplace Voluntary Benefits: Optional riders availability based on employer / g	group election.								
Accident									
	C								
Office use only Group # Benefit #	Class # Div #								
	[O 1-6] [O 1-6] [O 1-6] [O 1-6]								
<b>Coverage type:</b> [O Employee / Individual only] [O Employee / Individual and spouse] [O Family]	[O Employee / Individual and child(ren)]								
[O Optional Hospital Intensive Care Unit Benefits Rider]  [O \$1-50,000] [per day][per month][per year]  [O \$1-50,000] [per day][per month][per year]  [O \$1-50,000] [per day][per month][per year]  [O Optional Fracture and Dislocation Benefits Rider]  [O Optional Accident Total Disability Benefits Rider: Elimination Period]  [O 1-120] [Month][Days][Year]									
Accident - 2012									
Office use only Group # Benefit #	Class # Div #								
[O Accident] [O N O Y] [Benefit Level:] [O 1-6] [O 1	-6] [O 1-6] [O 1-6] [O 1-6] [O 1-6]								
[Coverage type:] [O Employee / Individual only] [O Employee / Individual and spouse] [O Family]	[ Employee / Individual and child(ren)]								
[O Pet Lodging [O \$1-1,000][per day][per month][per year] [O \$1-1,000][per day][per [O \$1-1,000][per day][per month][per year] [O \$1-1,000][per day][per day									
Disability Income Plus									
Office use only Group # Benefit #	Class # Div #								
[○ Disability Income Covering Accident and Sickness][○ N ○ Y]  [Base Benefit Period:] [○ 1-120] [Month][Days][Year] [○ 1-500][○ 0-500]	/ear] [○ 0-500][/ 0-500]								
O Disability Income Covering Accident and Sickness with Waiver of Elimination Period] O N  [Base Benefit Period:] [○ 1-120] [Month][Days][Year][○ 1-120][Days][Year]  [○ 1-120] [Month][Days][Year]  [○ 1-120] [Month][Days][Year]  [O 1-120] [Month][Days][Year]  [Base Elimination Period:] [○ 0-500][/ 0-500][/ 0-500]]  [○ 0-500][/ 0-500][/ 0-500][/ 0-500]]  [Optional Disability Income Benefits: [○ ICU/CCU Benefit] [○ \$1-2,000]	[Monthly Benefit state of the control of the contro								
[Optional Disability income Benefits: [O 1007000 Benefit] [O \$1-2,000] [O \$1-2,000] [O Physical Therapy Benefit]  [O COBRA Rider]	\$1-2,000]								

6

Last name:	First name:
Disability Income Advantage	
Office use only Group # Benefit #	Class # Div #
[O Disability Income Advantage] [O N O Y]	
[Sase Benefit Period:] [○ 1-120] [Month][Days][Year] [○ 1-120] [Month][Days] [○ 1-120] [Month][Days][Year] [○ 1-120] [Month][Days] [○ 1-120] [Month][Days][Year] [Sase Elimination Period:] [○ 0-500][/ 0-500]] ○ 0-500][/	[Year]
[Optional Riders:] [O Hospital Confinement] [O COBRA Rider]	0]] \$
Whole Life [/ AD&D]	
Office use only Group # Benefit #	Class # Div #
[O Whole Life] [/ AD&D] [O N O Y] [O Whole Life 99] [O Whole Life 90] [O Whole Life	Life 65] [Employee / Individual Benefit \$ .00]  [O Family Term Rider Spouse Benefit \$
[O \$1-120 /] [Days][Week][Month][Year] \$]	Child(ren) Benefit \$]
Whole Life Spouse [/ AD&D]	
Office use only Group # Benefit #	Class # Div #
[ Whole Life Spouse] [/ AD&D] [ N O Y] [ Whole Life 99] [ Whole Life 90] [ Whole Life 90] [ Whole Life 90] [ AD&D Rider ] [ Automatic Premium Loan Option] [ Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount \$]	Vhole Life 65] [Spouse Benefit \$ .00]
Whole Life Child(ren) [/ AD&D]	
Office use only Group # Benefit #	Class # Div #
[ Whole Life Child(ren)] [/ AD&D] [ N O Y ]	
Child(ren) listed here must also be included as dependents under the Enrollment Information	-
O N O Y Coverage on Child 1 Child 1 Name O N O Y Coverage on Child 2 Child 2 Name O N O Y Coverage on Child 3 Child 3 Name	Child 2 Benefit \$]
Level Term Life	
Office use only Group # Benefit #	Class # Div #
O Level Term Life] O N O Y] [Coverage type:] [O Employee / Individual only] [O Base Plan:][O 10 Year Term] [O 20 Year Term] [Optional Benefit:] [O Automatic Benefit Increase]	Spouse] [ Child(ren) ] [ No Coverage]
[Employee / Individual Benefit [Spouse Benefit	[Child(ren) Benefit
\$ .00] \$ .00] \$ .00] \$ .00] \$ .00] \$ .00] [If your employer or group has elected the critical illness rider, have you or any of with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to [If yes, please indicate whether this applies to you (employee / individual), your spouse or a complex of [O You (employee / individual)] [O Spouse] [O Dependent] [Name	age [1-100]? O N O Y ]
Term to 95	
Office use only Group # Benefit #	Class # Div #
[O Term to 95] [O N O Y] [Coverage type:] [O Employee / Individual only] [O Sp	
[Employee / Individual Benefit [Stand alone Spouse Benefit \$	[Stand alone Child(ren) Benefit \$ .00]

Last name:	First name:
Critical Illness Expense	
Office use only Group # Benefit #	Class # Div #
	bloyee / Individual only] [  Employee / Individual and spouse] bloyee / Individual and child(ren)] [ Family]
[Optional Benefits:] [O Automatic Benefit Increase] [O Health Screening] [O Return on Premium]	[Employee / Individual Benefit \$ .00]
[Have you or any dependent had a parent, brother, or sister with a histodiagnosis prior to age [1-100]? O N O Y] [ If yes, please indicate whether the dependent. [O You (employee / individual) [O Spouse] [O Dependent] [Name_	
Group Lump Sum Cancer	
Office use only Group # Benefit #	Class # Div #
	bloyee / Individual only] [O Employee / Individual and spouse] bloyee / Individual and child(ren)] [O Family]
[Have you or any dependent had a parent, brother, or sister with a history of cance [If yes, please indicate whether this applies to you (employee / individual), your sport [O You (employee / individual)] [O Spouse] [O Dependent] [Name	
Rider: O Automatic Benefit Increase [O Health Screenings]   [Benefit   Streenings   Figure   Streenings   Str	, [ .00]
Cancer Expense	
Office use only Group # Benefit #	Class # Div #
	oloyee / Individual only] [O Employee / Individual and spouse]
[Dase Benefit \$ 00]	oloyee / Individual and child(ren)] [O Family]
	spital Indomnity Paga Panafit Diday
[O Lump Sum Benefit (Equal to 50% of Base Benefit Amount)] [Rider:] [O Ho Supplemental Health	ispital indentifity base benefit kiderj
Office use only Group # Benefit #	Class # Div #
	ployee / Individual only] [ © Employee / Individual and spouse]
	ployee / Individual and child(ren)] [  Family]
Beneficiary Information for Life, Disability and Workplace	e Voluntary Benefits
Primary beneficiary Last name Fi	rst name MI
Relationship to employee / individual	
Secondary beneficiary	
	st name MI
Relationship to employee / individual	

	<b>Evidence of Health Status</b>																						
in cc	This information should not be submitted more than [1-60] days prior to the effective date. [Complete this section for individuals, including dependents, enrolling or applying for [medical,] [disability,] [life] [or] [workplace voluntary benefit] coverage.]																						
	Long Term Disability] [and] [Short Term Disability] if the				_				•					,									
[1	[1-3.] [Over Guaranteed Issue Limit: Election of coverage exceeding the guaranteed issue amount (according to your policy) for which evidence of insurability is required.]																						
	<ul> <li>[1-3.] [Opting up to Higher Level of Coverage: election of additional increments of coverage with insurance currently in force.]</li> <li>[1-3.] [Late Entrant: Employee who did not enroll during one of the following eligibility periods: initial eligibility date of hire or date of family status change, or during an annual enrollment and does not currently have coverage in force.]</li> </ul>																						
	[-8.][Within the past [1-12] months have you or, if applicable, y please indicate whether this answer applies to you (employe	e /	/inc	livid	ual	) or	your	spo	use 🔾 Ĕ	mplo	yee	/În	divi	dua	O l	S	oou:	se		0	N	0	Y]
[1-8.] [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?										N	0	Y]											
	[In the past [1-12] months, have you missed [1-5] or more result of a cold, the flu, back problems], strained/sprained	/fra	actı	urec	l/br	oke	ń lim	b oı	r as a res	sult c	of pr	égn	anc	y?							N		
	[Have you or any dependent been diagnosed or received t an AIDS-related complex?																				N	0	Y]
[1	[1-8.] [Within the past [1-5] years, have you or any eligible dependent to be covered been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:]																						
[[8	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries or blood disorders; anemia; hemophilia; phlebitis; high blood pressure [(reading higher than 140/90 or above)]?  Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?  O N O Y O O O O O O O O O O O O O O O O O O										N Y												
[a	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?  Stomach, gall bladder, digestive, intestinal or colon disorders?												N										
[a 0	Stroke; Transient Ischemic Attack (TIA)?  O N T I [a- o.] Rheumatoid arthritis[; [or] back disorders; or joint of disorders]?											Υ_											
	respiratory organs?	о О	N Y	]		[a:		_	is, or an								nt oi	r de	forn	nity?		<b>O</b>	N Y
	i.]	0	N Y			[a	1		c Fatigue	,													N Y
	<u>.]</u>	0	Υ	┚		(a.			es of the				se o	r th	roa	t?					-	<u> </u>	$N_{Y}$
[8	<u></u> ]		Υ	_		(a.		oho	lism or o	drug	habi	t?											$\begin{bmatrix} N \\ Y \end{bmatrix}$
[a		$\circ$	N Y																				
[1	-8.] [Has any proposed Insured been advised by a member of hospitalization, or surgery that has not been completed w									ny di	agn	ostic	tes	st,						O	N	<b>O</b>	Y]
[1	<b>1-8.</b> ] [Within the past [1-5] years, has anyone enrolling or apply routine physical/wellness exam, or been seen for any reas	/ing	g fo	or co	ove evi	rag ous	e see ly dis	n a clos	health c ed?	are p	rovi	der	or s	pec	ialis	st f	or a			O	N	<b>O</b>	Y]
[1	-8.] [Are you or any dependent to be covered pregnant? If yes [Anticipated delivery date:]	, p	lea	se ii	ndi	cate	anti	cipa	ited deli	very (	date	bel	OW.							O	N	C	<u>Y]</u>
	you answered "yes" to any of the questions above, plettach additional signed and dated sheets (reorder AR-5									and s	pe	ify	the	e qu	ıes	tio	n #	-					
	Question # & Letter (Person Treated) Last name First name MI																						
	ondition							] [rea	tments r	receiv	/ed												
																		T			Т		
M	Medications prescribed							ıırr	ent or fu	ıture	trea	atme	nts	or	med	dica	atio	ns					
141			T				[	- ai i		- care	., (			J1		J. C.					$\top$		
				15		· -	0.00	Λ.															
	Date diagnosed (MM/DD/YYYY)  Date last seen by a diagnosed (MM/DD/YYYYY)	loc /	tor	(N	IM/	'DD	/YYY`	()															
		,																					

First name:

Last name:

have waived any coverage offered to me or my dependents, my signature below is evidence of this action.										
I hereby waive coverage for (check all th		, , 5		I decline to apply for group coverage						
[Medical for:	O Myself	O My spouse	O My dependent child(ren)]	because of:						
[Dental for:	• Myself	O My spouse	• My dependent child(ren)]	[O Spousal coverage]						
[Basic Life for:	Myself	O My spouse	• My dependent child(ren)]	[O Medicare supplement]						
[Voluntary Life for:	Myself	O My spouse	<ul><li>My dependent child(ren)]</li></ul>	[O Individual coverage]						
[Vision for:	Myself	O My spouse	<ul><li>My dependent child(ren)]</li></ul>	O Coverage under another carrier's plan						
[Group Term Life for:	Myself]			provided by my employer / group]						
[Short Term Disability for:	Myself]			Other:						
[Long Term Disability for:	• Myself]			1						
[Health Savings Account for:	Myself]			<del></del> -						
[Flexible Health Account for:	• Myself]									
[Flexible Dependent Care Account for:	• Myself]									
Waive Coverage for Workplace Vo		efits:								
[Whole Life for:	O Myself	• My spouse	• My dependent child(ren)]							
[Level Term Life for:	O Myself	O My spouse	• My dependent child(ren)]							
[Term to 95 for:	O Myself	• My spouse	• My dependent child(ren)]							
[Critical Illness Expense for:	O Myself	O My spouse	• My dependent child(ren)]							
[Group Lump Sum Cancer for:	Myself	O My spouse	• My dependent child(ren)]							
[Cancer Expense for:	Myself	O My spouse	• My dependent child(ren)]							
[Supplemental Health for:	Myself	O My spouse	• My dependent child(ren)]							
[Accident for:	• Myself	O My spouse	<ul><li>My dependent child(ren)]</li></ul>							
[Disability Income Plus for:	• Myself]									
[Disability Income Advantage for:	• Myself]									

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer /

## True and complete acknowledgement

I understand, agree, and represent:

Waiver (refusal of coverage)

• I have read the Large Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.

Last name:

- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Large Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate of insurance.
- If I have a new dependent as a result of a qualifying event, I may
  in the future be able to enroll myself or my dependents provided I
  request enrollment within [1-31] days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Large Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-31] days after my other coverage ends.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I

- request enrollment within [1-60] days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.

First name:

- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Large Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Large Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny claims or void the contract or coverage within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Large Group Employee and Individual Application and Enrollment Form by Humana.

	Last name:		First name:
Authorization			
<ul> <li>My dependents and I understand and age.</li> <li>The information obtained by use of the by Humana to make claims determined coverage, eligibility for benefits under administration.</li> <li>Any information obtained will not be person or organization except to reing information Bureau, Inc. or other person this Large Group Employee and Indivision, claim or as may be otherwise land further authorize.</li> </ul>	released by Humana to any suring companies, the Medical sons or organizations performing legal services in connection with dual Applications and based on the Medical services in connection with dual Application and Enrollment	Disability If my dependents party to have informon-medical informulation Humana, its reinsupersonal and healis disclosed pursua	for Release of Medical Records for Life or or I have selected life or disability, I authorize any third rmation regarding myself. This includes any medical or mation and to share any and all such information with urer or its legal representatives, and its affiliates. Once th (including medical, dental and pharmacy) information ant to this authorization, the recipient may redisclose tion may not be protected by federal and state privacy
The Large Group Employee and I make up part of any contract and	ndividual Application and Enro d be the basis for any policy or	llment Form, togo certificate	ether with any supplemental forms, will
Signature - Please sign below	if enrolling or waiving any gro	oup coverage	

# **Agent / Producer Information**

Name and relationship of legal representative

(if a covered dependent)

Employee / Individual or legal representative signature

Signed at \_\_\_\_

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	2. Agent / Agency of Record:
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:
1. Writing Agent / Producer:	2. Writing Agent / Producer:
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? O N O Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Large Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

	•		
Writing Agent's Signature		Date/_	/

State

County

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

SERFF Tracking Number: HUMA-128309463 Arkansas State:

Filing Company: Kanawha Insurance Company State Tracking Number:

Company Tracking Number: AR-12-006 KIC WVB

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Applications (KIC) WVB

Project Name/Number: SB Life Enhancement/AR-12-006 KIC SBE

# **Supporting Document Schedules**

Item Status: **Status** 

Date:

Flesch Certification Approved-Closed Satisfied - Item: 05/01/2012

Comments: see below

**Attachment:** 

KIC readability.pdf

**Item Status:** Status

Date:

Application Approved-Closed 05/01/2012 Bypassed - Item:

**Bypass Reason:** na

**Comments:** 

Item Status: **Status** 

Date:

Health - Actuarial Justification Approved-Closed 05/01/2012 Bypassed - Item:

N/A **Bypass Reason:** 

Comments:

**Item Status: Status** 

Date:

Bypassed - Item: Outline of Coverage Approved-Closed 05/01/2012

**Bypass Reason:** N/A

Comments:

**Item Status: Status** 

Date:

**PPACA Uniform Compliance** Approved-Closed Bypassed - Item: 05/01/2012

Summary

**Bypass Reason:** 

**Comments:** 

N/A

SERFF Tracking Number: HUMA-128309463 State: Arkansas

Filing Company: Kanawha Insurance Company State Tracking Number:

Company Tracking Number: AR-12-006 KIC WVB

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Applications (KIC) WVB

Project Name/Number: SB Life Enhancement/AR-12-006 KIC SBE

Item Status: Status

Date:

Satisfied - Item: Statement of Variability Approved-Closed 05/01/2012

**Comments:** see attached

Attachment:

Statement of Variability. Application.pdf

# KANAWHA INSURANCE COMPANY CERTIFICATE OF READABILITY

RE: GROUP INSURANCE APPLICATION FILING
KANAWHA INSURANCE COMPANY
NAIC # 119-65110 (KIC)
Filing # AR-12-003 KIC SBE

I, Gerald L. Ganoni, an officer of Kanawha Insurance Company, hereby certify that I have authority to bind and obligate the company by the filing of these forms. I further certify that, to the best of my knowledge, information and belief, the above stated forms do meet the Flesch reading ease test achieving a minimum score of forty (40).

2

Gerald L. Ganoni, Vice -President

April 26, 2012



#### **Statement of Variability for Application Forms**

#### **Bracketed Sections**

- 1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, payment information, or agreements.
- 2. Bracketed sections are identified by green brackets.

**NOTE**: Some exceptions will apply due to state requirements or rulings regarding bracketing.

- 3. Non-bracketed logos, text, or numbers within the section remains constant and will not be subject to changes without being refiled.
- 4. Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to any statutory or regulatory requirements.
  - For example: We have filed the Dental section of an application but the applicant did not select Dental then that section will not appear.
- 5. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

#### **Bracketed Numbers**

- 1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.
  - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.
  - Reorder numbers (Group forms) and Revision numbers (Individual forms) are located in the lower right-hand corner of the form and are considered variable and included within this statement.
- 2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.
- 3. Bracketed numbers will include the minimum and maximum ranges.
- 4. If the state determines ranges are not acceptable, only a single number will be shown on the form and that number will not be bracketed.

#### **Bracketed Questions**

- 1. Text within the bracketed question will not change (Refers to language only. See # 3 for formatting and placement changes).
- 2. Any bracketed variables within that question are subject to change.
- Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

## Instructions or Help Text

- 1. Bracketed instructional text varies to the extent that such text may be included, omitted or transferred to another page to meet the needs of applicants completing the application.
- 2. Humana reserves the right to make minor instructional or help text revisions, even if it is not bracketed, as needed to clarify instructions for completion of the application and amend the language to clarify the intent within the confines of the law.

#### **Product Information**

- Product information may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements
- Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
  - prior approval of certificate or policy forms for the new products or benefits;
     and,
  - any statutory or regulatory requirements

### **Legal Entities**

- 1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.
- Legal entities will be bracketed when multiple entities are listed as insuring or administering entities. The applicable entity(s) will be shown based upon the applicant's/groups selection.
- 3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

## **Demographic Information**

Demographic information will not be bracketed but will fall under administrative changes which can be amended without refiling.

# **Administrative Changes and Clerical Errors**

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.